Ambulance

Provider Manual
Volume II

July, 2023

New Hampshire
Medicaid

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Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication
7/26/2023	N/A	4	Moved information from #3 to a bullet under #2	Edited bullets to fix a typo	N/A

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes, which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices section encompasses a range of supplemental materials such as Fee Schedules, Contact Information, Common Acronyms, and other general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

1.4 Notifications & Updates

Providers are notified of NH Medicaid Program changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, memos, letters, web site updates, newsletters and/or updated pages to the General Billing Manual – Volume I and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

This manual applies to ambulance service providers, including both ground and air ambulance transportation.

In order to provide NH Medicaid ambulance services, the ambulance provider must:

(a) Be licensed in the state in which they operate; and

(b) Be an enrolled New Hampshire Medicaid provider.

Many ambulance providers serve NH Medicaid recipients through the Non-Emergency Medical Transportation program as well as directly through the NH Medicaid for emergency trips and facility to facility transfers. It is the responsibility of the ambulance provider to determine the appropriate party to bill for services provided. The NEMT broker will deny any misdirected claims. The Department has developed the Ambulance Provider Reference Guide to assist providers in determining the appropriate party to bill for the trip.

3. Covered Services

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

There are two categories of covered ambulance services:

1. Non-Emergency Medical Transportation (NEMT): Ambulance services covered under the NEMT program are scheduled and routine ambulance trips. "Scheduled and routine ambulance trips" means transportation by ambulance for the purpose of attending an appointment to obtain a Medicaid covered service from a Medicaid enrolled provider when the use of any other mode of transportation would likely endanger the health and safety of the member and when the Medicaid covered service is not to treat an emergency medical condition. Non-emergency medical transportation services are managed by the State's contracted transportation broker. Ambulance providers must enroll with, and follow the guidelines of, the transportation broker in order to provide scheduled and routine ambulance trips.

    - Members must have an up to date Mobility Determination for Non-Emergency Medical Transportation on file indicating the medical necessity for ambulance services for scheduled and routine trips. Please see service authorization section for more detail.

2. Emergency and Facility Transfers: Ambulance services that are managed outside of the NEMT program include emergency trips necessitated by a member's emergency medical condition as well as facility to facility transfers. Ambulance providers must enroll with, and follow the guidelines of, the Department in order to provide these ambulance services. These ambulance trips are covered as follows:

    a. Transportation to the nearest acute care hospital with appropriate treatment facilities, including loaded mileage and routine, disposable supplies used en-route;

    b. Transportation from an acute care hospital ED to an inpatient psychiatric facility for admission;

    c. Transportation from one acute care hospital to another acute care hospital when the necessary treatment or diagnostic testing cannot be provided by the originating hospital and the member is discharged from the originating hospital; and

    d. Waiting time as follows:

        - Prior to transporting the member while the member is being stabilized; and
        - Up to a maximum of 2 hours, rounded to the nearest half-hour.

e. Air ambulance services, in the case of an emergency medical condition, shall be covered if the member's condition is such that:

- The member cannot be safely transported in a timely manner via an Advanced Life Support (ALS) ground transportation with appropriate staff; and
- The member is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the member to the nearest facility capable of treating the member.

Air ambulance service claims will be reviewed retrospectively, on a case-by-case basis, to determine if the member was at imminent risk of losing life or limb if the fastest means of transport was not utilized to move the member to the nearest facility capable of treating the member, and the member could not be safely transported in a timely manner via an ALS ground transportation with appropriate staff. Payment for air ambulance services provided to a member shall only be allowed when the noted conditions are met and only when supported by medical documentation on file. Claims for air ambulance services that do not meet these criteria will be denied for payment, and it will be the responsibility of the hospital that requested the service to pay the cost of the claim.

3.1 Service Limits

There are no service limits on ambulance transportation at this time.

4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, prior to delivery of the service, that it may be non-covered by NH Medicaid and that should the member still choose to receive the service, then the member may be responsible for payment for the service. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for it.

Non-covered ambulance services include:

(1) Transportation for a member whose condition permits transport in any type of vehicle other than an ambulance, such as a private vehicle or a wheelchair van, without endangering the member's health.

(2) Transportation which is ***not***:

- Scheduled and routine ambulance transportation (as defined in the "Terminology" section below); or
- For an emergency medical condition (as defined in the "Terminology" section below);
- Transportation of a member from one hospital to another inpatient facility (hospital or inpatient psychiatric facility) wherein the member is coming from the Emergency Department of the originating hospital or has been discharged from the originating hospital.

(3) Transportation by ambulance only for the member's or their family's convenience;

(4) Transportation to and from medical providers, unless the medical need for ambulance level of care is documented in the Mobility Determination for Non-Emergency Medical Transportation on file with the broker.

(5) Transportation from one acute care hospital to another acute care hospital for necessary treatment or diagnostic testing while the member maintains inpatient status with the originating hospital;

(6) Waiting time as follows:

- Waiting time that exceeds 2 hours; and
- Waiting time for transportation in the case of an emergency medical condition when the wait is not due to the member needing to be stabilized.

(7) Transportation of a member from an acute care hospital to another acute care hospital or medical provider to obtain necessary treatment or diagnostic testing not available while the member is still an inpatient of the originating acute care hospital. The transport is considered to be part of the DRG payment billed by the hospital.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The Contact Information in the Appendices of the General Billing Manual or on the SA form itself should be consulted for the name and method of contact.

For all scheduled and routine ambulance transports, the member must have a Mobility Determination for Non-Emergency Medical Transportation form on file with the broker which confirms that an ambulance is the only acceptable vehicle type that can transport the member to and from their scheduled and routine appointments.

A Mobility Determination that indicates that an ambulance will be provided to the member for scheduled and routine transportation will be authorized if:

(1) The member has a condition such that all other methods of transportation are contraindicated by the member's condition and therefore, the member cannot be transported by any other means from the origin to the destination without endangering the member's health; or

(2) The member is bed confined, meaning the member is (a) unable to get up from bed without assistance, (b) unable to ambulate; and (c) unable to sit in a chair or wheelchair.

The mobility form is intended to be valid indefinitely and can be modified at any time by submitting a new form.

For all emergency trips and facility to facility transfers, those trips which are not covered under NEMT and are instead billed directly to the member's health plan, a service authorization will not be required due to the urgency of the transport.

6. Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until resolution of any legal action(s) commenced in the six year period, whichever is longer. Please see the "Record Keeping" section of the General Billing Manual – Volume I, for documentation requirements.

Each ambulance provider shall maintain documentation in their records to fully support each claim billed for services, including:

(1) For emergency transportation, documentation of the nature of the member's emergency medical condition; and

(2) For all ambulance transportation, documentation that justifies the level of service, whether ALS or BLS, claimed.

For each trip billed, the ambulance provider shall maintain a run sheet or patient care report that includes at a minimum the following information, which is legibly written:

(1) Member name and Medicaid identification number;

(2) Date of service;

(3) Origin and destination;

(4) Member vital signs;

(5) Member signs and symptoms upon arrival at the point of pick-up;

(6) Member status en-route;

(7) Services provided;

(8) The name of the person who provided the service or care in the ambulance, including signature and credentials; and

(9) The response code that indicates the mode of response for the ambulance making the trip.

7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations, CMS transmittals, provider manuals, fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services, or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. Refer to Adverse Actions section of the General Billing Manual – Volume I regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the NH Medicaid program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume I. Providers who receive payment in full from a third party are not required to file zero-payment claims with NH Medicaid.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I

Medicare and commercial insurance plans do not cover non-emergency medical transportation services. Billing to Medicare or other commercial insurance plans is only applicable to emergency ambulance claims.

10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

Payment for emergency ambulance services shall be made in accordance with the rates established by the department. Payment for scheduled and routine ambulance services are made in accordance with the rates established by the transportation broker and outlined in the provider's contract with the transportation broker. The ambulance provider shall submit claims for ambulance trips to the Department's fiscal agent or to the Department's NEMT broker as applicable. Ambulance service providers may submit claims to the fiscal agent using paper or electronic billing.

Payment shall consist of the following separate components, as applicable:

(1) A base rate;

(2) A mileage rate, which shall be paid for the most direct route to and from a destination and for loaded miles only, which:

- Shall be the distance traveled while transporting a member from a pick-up point to a drop-off point;
    - NH Medicaid now allows for the reporting of fractional mileage amounts on ambulance claims in order to improve reporting and payment accuracy. Providers and suppliers who are submitting fractional mileage must use a decimal point in the appropriate place. Rounding to the nearest tenth of a mile is permitted.
- Does not include mileage incurred on the way to pick up a member or after dropping off a member;

(3) Payment for waiting time (as allowed under the "Covered Services" section); and

(4) Payment for routine disposable supplies used en-route.

Payment shall be made for only one mileage charge per trip regardless of the number of members transported.

Payment shall be based on the level of service provided, not on the vehicle used, even if the local government requires an ALS response for all calls.

The ambulance provider shall not bill NH Medicaid for transporting a member from an acute care hospital to another acute care hospital or medical provider to obtain necessary treatment or diagnostic testing not available while the member is still under inpatient care of the originating hospital.

11. Claims

Please note that the below information applies only to the claims submitted to NH Medicaid and not those claims submitted to the NH Medicaid NEMT broker.

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes for the date of service on the claim. One procedure or revenue code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

Transportation procedure codes include two levels of ambulance services: Basic Life Support and Advanced Life Support. These are recognized by specific procedure codes used for billing. Claims must be submitted with the correct procedure code for the level of service provided.

Ambulance transportation cannot be billed with date spans. Each mileage occurrence must be billed with one date of service per claim. NH Medicaid now allows for the reporting of fractional mileage amounts on ambulance claims in order to improve reporting and payment accuracy. Providers and suppliers who are submitting fractional mileage must use a decimal point in the appropriate place. Rounding to the nearest tenth of a mile is permitted.

11.2 Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

For all emergency trips and hospital-to-hospital transfers, those trips which are not covered under NEMT and are instead billed directly to the member's health plan, a service authorization will not be required due to the urgency of the transport.

11.3 Claim Completion Requirements for Ambulance Services

Ambulance providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

For additional guidance on how to complete a CMS1500 claim form please refer to the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

12. Terminology

Acute Care Hospital: A hospital that provides short-term medical treatment for patients who have an acute illness or injury, or who are recovering from surgery.

Advanced Life Support (ALS) Services: Medical procedures and the scope of practice rendered by advanced emergency medical care providers in accordance with RSA 153-A:12.

Air Ambulance: A fixed-wing or rotary-wing aircraft that is certified by the Federal Aviation Administration as an air ambulance and which is designed and equipped for the provision of medically necessary supplies and services.

Ambulance: Any vehicle designed, equipped, and used for the transport of sick or injured individuals and which are licensed to do so in the state in which they operate.

Basic Life Support (BLS) Services: Fundamental medical procedures and the scope of practice in which emergency medical care providers at the first responder or emergency medical technician-basic levels are trained.

Emergency medical condition: Means either of the following conditions:

(1) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer may pose a threat to the health or safety of the woman or unborn child.

Scheduled and routine ambulance transportation: Transportation by an ambulance for the purpose of attending an appointment to obtain a Medicaid covered service from a Medicaid enrolled provider when the use of any other mode of transportation would likely endanger the health and safety of the member and when the Medicaid covered service is not to treat an emergency medical condition.