Notice Number _____ Rule Number **He-W 572**

1. Agency Name & Address: **Department of Health and Human Services** **Division of Medicaid Services** **129 Pleasant Street, Brown Bldg.** **Concord, NH 03301**	2. RSA Authority: **RSA 161:4-a, XII** 3. Federal Authority: _____ 4. Type of Action: Adoption _____ Repeal _____ Readoption _____ Readoption w/amendment **X**

5. Short Title: **Ambulance Services**

6. (a) Summary of what the rule says and of any proposed amendments including whether the rule implements a state statute for the first time:

He-W 572 sets forth the requirements for ambulance services under the New Hampshire Medicaid program. Specifically, He-W 572 describes covered and non-covered services, explains the authorization requirements and procedures for non-emergency ambulance transportation, and includes information for providers including documentation and payment requirements. He-W 572 is currently an interim rule and scheduled to expire on June 26, 2024.

The Department of Health and Human Services (Department) is proposing to readopt with amendment He-W 572. The proposed amendments include:

- **Updating the rule for better clarity, program integrity, and to be consistent with language used in other rules that have been more recently adopted;**
- **Updating He-W 572.01 on definitions by amending the definition of "advanced life support (ALS) services" and "basic life support services";**
- **Updating He-W 572.04 on covered services by clarifying that emergency transportation from an acute care hospital to an inpatient psychiatric facility is a covered service, removing the wait time requirements, and making other editorial changes;**
- **Updating He-W 572.05 on non-covered services by further clarifying that ambulance transportation from one hospital to another inpatient facility wherein the member is coming from the emergency department of the originating hospital or has been discharged from the originating hospital services is a covered service, by removing transportation to and from medical providers as a non-covered service, by revising the waiting time to remove when an emergency medical condition does not require stabilization, and by making other editorial changes; and**
- **Updating He-W 572.06 on authorization requirements for scheduled and routine ambulance transportation by re-titling the section to "Mobility Determination Requirements for Scheduled and Routine Ambulance Transportation" and eliminating the use of 2 forms and replacing them with the form "Mobility Determination for Non-Emergency Medical Transportation Universal Form for All Medicaid Plans".**

6. (b) Brief description of the groups affected:

This rule affects Medicaid recipients, ambulance service providers, and recipients' health care providers.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

RULE	STATE OR FEDERAL STATUTE OR REGULATION THE RULE IMPLEMENTS
He-W 572.01	42 CFR 440.170
He-W 572.02	42 CFR 440.210; 42 CFR 440.220
He-W 572.03	42 CFR 440.60; RSA 153-A:11; 42 CFR 440.170
He-W 572.04	42 CFR 440.170
He-W 572.05	42 CFR 440.170
He-W 572.06	42 CFR 440.230
He-W 572.07	42 CFR 431.107
He-W 572.08	42 CFR 455
He-W 572.09	42 CFR 433.139
He-W 572.10	RSA 541-A:21, III; 42 CFR 447.200; 42 CFR 447.202; 42 CFR 447.204

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name: **Allyson Raadmae** Title: **Administrator- Administrative Rules Unit**

Address: **Dept. of Health and Human Services**
Administrative Rules Unit
129 Pleasant Street, 2nd Floor
Concord, NH 03301

Phone #: **(603) 271-9604**
Fax#: **(603) 271-5590**
E-mail: **Allyson.E.Raadmae@dhhs.nh.gov**

TTY/TDD Access: Relay NH 1-800-735-2964
or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
https://www.dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-rules/nh-administrative-rules-public-comment

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Monday, April 15, 2024**

☒ Fax ☒ E-mail ☐ Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Monday, April 8, 2024 at 1:00 p.m.**

Physical Location: **DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH**

Electronic Access (if applicable): **N/A**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant):

FIS # **24:030** , dated **February 27, 2024**

1. **Comparison of the costs of the proposed rule(s) to the existing rule(s):**
There is no difference in cost between the proposed rules and the existing rules.

2. **Cite the Federal mandate. Identify the impact on state funds:**
No federal mandate, no impact on state funds.

3. **Cost and benefits of the proposed rule(s):**

A. To State general or State special funds:
None.

B. To State citizens and political subdivisions:
None.

C. To independently owned businesses:
None.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

The proposed rule modifies an existing program or responsibility, but does not mandate any fees, duties, or expenditures on the political subdivisions of the state, and therefore does not violate Part I, Article 28-a of the N.H. Constitution.

Readopt with amendment He-W 572, effective 12-29-23 (Document #13840, Interim), to read as follows:

PART He-W 572 AMBULANCE SERVICES

He-W 572.01 Definitions.

(a) "Acute care hospital" means a hospital that provides short-term medical treatment for patients who have an acute illness or injury, or who are recovering from surgery.

(b) "Advanced life support (ALS) services" means "advanced life support (ALS)" as defined by Saf-C 5901.05~~04~~, namely, "medical procedures and the scope of practice rendered by advanced emergency medical care providers in accordance with RSA 153-A:12."

(c) "Air ambulance" means 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.

(d) "Ambulance" means 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.

(e) "Basic life support (BLS) services" means "basic life support (BLS)" as defined by Saf-C 5901.10~~09~~, namely, "fundamental medical procedures and the scope of practice in which emergency medical care providers at any of the following licensing ~~the first responder or emergency medical technician-basic~~ levels are trained:

(1) Emergency medical responder;

(2) New Hampshire emergency medical technician-basic (NH-EMT-B); or

(3) Emergency medical technician (EMT)."

(f) "Department" means the New Hampshire department of health and human services.

(g) "Emergency medical condition" means:

(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 recipient, 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.

(h) "Medicaid" means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

(i) "Prior authorization agent" means an individual or agency contracted by the department responsible for reviewing all scheduled and routine ambulance transportation requests.

(j) "Recipient" means an individual who is eligible for and receiving medical assistance under the medicaid program.

(k) "Scheduled and routine ambulance transportation" means 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 recipient and when the medicaid covered service is not to treat an emergency medical condition as defined in (g) above.

(l) "Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(m) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

He-W 572.02 Recipient Eligibility. All recipients shall be eligible for ambulance services, in accordance with He-W 572.

He-W 572.03 Provider Participation. All participating ambulance providers shall:

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

(b) Be an enrolled New Hampshire medicaid provider.

He-W 572.04 Covered Services.

(a) The following ambulance services, in the case of an emergency medical condition, shall be covered:

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

(2) Transportation from an acute care hospital emergency department to an inpatient psychiatric facility for admission; and

(32) 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 recipient is discharged from the originating hospital.; and

~~(3) Waiting time for transportation as follows:~~

~~a. Prior to transporting the recipient while the recipient is being stabilized; and~~

~~b. Up to a maximum of 2 hours, rounded to the nearest half-hour.~~

(b) Air ambulance services, in the case of an emergency medical condition, shall be covered if the recipient's condition is such that:

(1) The recipient cannot be safely transported in a timely basis via an ALS ground transportation with appropriate staff; and

(2) The recipient is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the recipient to the nearest facility capable of treating the recipient.

(c) Scheduled and routine ambulance transportation, as defined in He-W 572.01(k), to and from the destination, including loaded mileage and routine disposable supplies used en-route, shall be covered when the service has been determined medically necessary~~is authorized~~ in accordance with He-W 572.06.

(d) Waiting time for scheduled and routine ambulance transportation authorized pursuant to He-W 572.06 shall be covered up to a maximum of 2 hours, rounded to the nearest half hour.

He-W 572.05 Non-Covered Services. Non-covered ambulance services shall include:

(a) Transportation for a recipient 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 recipient's health;

(b) Transportation in an ambulance which is not:

(1) Scheduled and routine ambulance transportation, as defined in He-W 572.01(k); ~~or~~

(2) For an emergency medical condition, as defined in He-W 572.01(g); or

(3) Transportation of a member from one hospital to another inpatient facility such as a 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;

(c) Transportation by ambulance only for the recipient's or his or her family's convenience;

~~(d) Transportation to and from medical providers, unless authorized in accordance with He-W 572.06;~~

(d~~e~~) Transportation from one acute care hospital to another acute care hospital for necessary treatment or diagnostic testing while the recipient maintains inpatient status with the originating hospital; and

(e~~f~~) Waiting time that exceeds 2 hours.~~, as follows:~~

~~(1) Waiting time that exceeds 2 hours; and~~

~~(2) Waiting time for transportation in the case of an emergency medical condition when the wait is not due to the recipient needing to be stabilized.~~

He-W 572.06 Mobility Determination~~Authorization~~ Requirements for Scheduled and Routine Ambulance Transportation.

(a) Medical necessity of a scheduled and routine ambulance transportation shall be documented using the "Mobility Determination for Non-Emergency Medical Transportation Universal Form for All Medicaid Plans" (XXXX 2024), ~~require authorization~~ to be a covered service.

(b) A complete ~~authorization~~ "Mobility Determination for Non-Emergency Medical Transportation Universal Form for All Medicaid Plans" (XXXX 2024)~~request~~ shall be signed and submitted by a healthcare

professional such as a registered nurse, medical doctor, care manager, or case manager to the department or its designee by either fax or mail.~~:~~

~~(1) Be submitted by the ambulance provider to the department or its prior authorization agent by either fax or mail; and~~

~~(2) Include the following forms, completed and legible:~~

~~a. Form 272AMB "Scheduled and Routine Ambulance Transportation Authorization Request Form" (3/13) signed and dated by the ambulance provider; and~~

~~b. Form 272MN "Medical Necessity for Ambulance Services Form" (3/13) dated and signed by the recipient's attending physician, doctor of osteopathy, physician assistant, clinical nurse specialist, advanced practice registered nurse, registered nurse, licensed practical nurse, or discharge planner employed by the facility where the recipient is being treated certifying:~~

~~"That I have personal knowledge of the recipient's condition. I further certify that the above information is true and correct based on my evaluation, and represents that that the recipient requires transport by ambulance. I understand that this information will be used to support the determination of medical necessity and payment for ambulance services by the NH Medicaid program".~~

(c) ~~Authorization~~ Mobility determination requests shall be submitted prior to ~~or within 30 days of the service being delivered.~~claiming for the service.

~~(d) A complete authorization request shall be approved by the department or its prior authorization agent if:~~

(d) The department or its designee shall utilize the "Mobility Determination for Non-Emergency Medical Transportation Universal Form for All Medicaid Plans" to determine the most appropriate vehicle type to meet the recipient's medical needs and notify the recipient of the determination, and include information that the recipient may appeal the department or designee's decision as to the most appropriate vehicle type for transportation according to medical necessity, in accordance with He-C 200.

~~(1) The recipient is bed confined, as described in (e) below; or~~

~~(2) The recipient has a condition such that all other methods of transportation are contraindicated by the recipient's condition, and therefore, the recipient cannot be transported by any other means from the origin to the destination without endangering the recipient's health.~~

~~(e) In order to be considered bed confined, a recipient shall be:~~

~~(1) Unable to get up from bed without assistance;~~

~~(2) Unable to ambulate; and~~

~~(3) Unable to sit in a chair or wheelchair.~~

~~(f) Authorizations shall be approved for a specified number of trips over a specified period of time, not to exceed a maximum of 3 months, after which a new complete authorization request shall be submitted in accordance with (b) above.~~

~~(g) If the department or its prior authorization agent denies the authorization request, it shall forward a notice of denial to the recipient and the requesting provider on the department Form 272a, "New Hampshire Title XIX Program Denial for Requested Services/Equipment" including the following:~~

~~(1) The reason for, and legal basis of, the denial; and~~

~~(2) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.~~

He-W 572.07 Documentation.

(a) Each ambulance provider shall maintain supporting records in accordance with He-W 520.

(b) 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 recipient's emergency medical condition; and

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

(c) For each trip billed in (b) above, 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) Recipient name and medicaid identification number;

(2) Date of service;

(3) Origin and destination;

(4) Recipient vital signs;

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

(6) Recipient 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.

He-W 572.08 Utilization Review and Control. The department shall monitor utilization of ambulance services, in accordance with 42 CFR 455, 42 CFR 456, and He-W 520.

He-W 572.09 Third Party Liability. All third party obligations shall be exhausted before medicaid may be billed, in accordance with 42 CFR 433.139.

He-W 572.10 Payment for Services.

(a) Payment for ambulance services shall be made in accordance with the rates established by the department in accordance with RSA 161:4, VI(a).

(b) 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:

a. Shall be the distance traveled while transporting a recipient from a pick-up point to a drop-off point; and

b. Does not include mileage incurred on the way to pick up a recipient or after dropping off a recipient;

(3) Payment for waiting time, as allowed by He-W 572.04(a)(3) and (d); and

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

(c) Payment shall be made for only one mileage charge per trip regardless of the number of recipients transported.

(d) 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.

(e) The ambulance provider shall not bill medicaid for transporting a recipient from an acute care hospital to another acute care hospital or medical provider to obtain necessary treatment or diagnostic testing not available while the recipient is still an inpatient of the originating acute care hospital.

(f) The ambulance provider shall submit claims for payment to the department's fiscal agent.

APPENDIX

RULE	STATE OR FEDERAL STATUTE OR REGULATION THE RULE IMPLEMENTS
He-W 572.01	42 CFR 440.170
He-W 572.02	42 CFR 440.210; 42 CFR 440.220
He-W 572.03	42 CFR 440.60; RSA 153-A:11; 42 CFR 440.170
He-W 572.04	42 CFR 440.170
He-W 572.05	42 CFR 440.170
He-W 572.06	42 CFR 440.230
He-W 572.07	42 CFR 431.107
He-W 572.08	42 CFR 455
He-W 572.09	42 CFR 433.139
He-W 572.10	RSA 541-A:21, III; 42 CFR 447.200; 42 CFR 447.202; 42 CFR 447.204

Mobility Determination for Non-Emergency Medical Transportation
Universal Form for All Medicaid Plans

The following form is intended to be completed by any health care professional working with the member, including a health plan care manager or nursing facility staff. The form is intended to be valid indefinitely and can be modified at any time by submitting a new form.

Who is the member enrolled with? Check below:

- ☐ **AmeriHealth Caritas New Hampshire**
- ☐ **BMCHP/WellSense**
- ☐ **NH Healthy Families**
- ☐ **NH Medicaid / Fee for Service**

Patient Information:

Last Name: _____ First Name: _____

Date of Birth: _____ NH Medicaid ID #: _____

Member Phone Number: _____ Height: _____ Weight: _____

Where does the member reside: _____

What mode of transportation is required?

- ☐ Car
- ☐ Wheelchair Vehicle
- ☐ Non-Emergency Ambulance
- ☐ Stretcher Van

Level of Mobility

- ☐ Patient requires assistance of trained personnel for safety
- ☐ Bed confined
- ☐ Unable to sit in a chair or wheelchair
- ☐ Requires a bariatric wheelchair or stretcher (select below)
  - ☐ Wheelchair (16-18 inches wide)
  - ☐ Bariatric Wheelchair (20-30 inches wide)
  - ☐ Stretcher (24 inches wide)
  - ☐ Bariatric Stretcher (37 inches wide)
- ☐ Unable to ambulate
- ☐ Unable to get up from bed without assistance
- ☐ Environmental factors like heat or cold affect the patient's mobility
- ☐ Unable to communicate needs
- ☐ Unable to remove self from unsafe situation
- ☐ Attendant/Escort

Wheelchair type:	☐ Manual	☐ Electric
Patient Self-propels:	☐ Yes	☐ No
Patient Self-transfers:	☐ Yes	☐ No
Patient travels with oxygen:	☐ Yes	☐ No
Patient ambulates independently:	☐ Yes	☐ No

Mobility Determination for Non-Emergency Medical Transportation
Universal Form for All Medicaid Plans

Does patient use any of the following assistive devices?

☐ Walker ☐ Crutches ☐ Cane ☐ Portable Oxygen ☐ Service animal

Does the patient have any of the following conditions:

☐ Alertness Issues ☐ Memory Issues ☐ Confusion ☐ Legally Blind ☐ Deaf

☐ Curb to Curb* ☐ Door to Door* ☐ Hand to Hand* ☐ Additional accommodation needs:

*Curb to Curb: Member does not need assistance getting in/out of the vehicle or getting to/from their appointment.

*Door to Door: Member does need some assistance getting to/from their residence or their appointment.

*Hand to Hand: Member requires assistance and supervision during the entire trip. Needs to be greeted at their residence and handed off to an assistant at their appointment.

Duration of Need: ☐ Permanent* ☐ Temporary (form should be updated annually)

**A new form only needs to be submitted if there is a change in condition.*

Healthcare professional such as RN, MD, Care Manager, Case Manager must complete, sign, and date this form and attest to the accuracy of the information provided.

Authorized Signature: _____ Date: _____

Provider (print name): _____ Title: _____

Phone Number: _____ NPI#: _____

Please fax or email this form to your health plan's transportation broker prior to scheduling your ride.

AmeriHealth Caritas New Hampshire	Phone: 833-301-2264 Fax: 203-375-0511	Nteamleads@ctstransit.com
MTM Contact Center for NH Healthy Families	Phone: 888-561-8747 Fax: 877-406-0658 ATTENTION: MTM Contact Center	payme@mtm-inc.net
BMCHP/ WellSense	Phone: 844-909-RIDE (7433) Fax: 203-375-0511	Nteamleads@ctstransit.com
NH Department of Health and Human Services (NH DHHS)	Phone: 844-259-4780 Fax: 203-375-0511	Nteamleads@ctstransit.com