Administrative Code

Title 23: Medicaid
Part 201
Transportation Services

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Subchapter 1: General

Rule 1.1.1: Ambulance Provider Enrollment Requirements

A. All ambulance providers whose origin, or site of pickup, is within the state of Mississippi, must be licensed in accordance with the requirements of the Mississippi State Department of Health, Office of Emergency Medical Services (OEMS) unless otherwise exempt. The exempt status is determined by the Office of Emergency Medical services. Any ambulance service provider who obtains a license and permit issued by the OEMS may qualify as a provider of ambulance service under the Medicaid program when the provider has met the requirements in Part 200, Chapter 4, Rule 4.8 in addition to the following:

   1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

   2. Copy of current provider license or permit.

   3. Written confirmation from the IRS confirming your tax identification number and legal business name.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.2: Definitions

A. Basic Life Support (BLS): Basic life support (BLS) ambulance services are supportive and non-definitive in nature. A basic ambulance is one that provides transportation plus the equipment and staff needed for such basic services as assessment and support of airway, breathing, oxygenation, and circulation; prevention of disability; and first aid including control of bleeding, splinting fractures, treatment for shock, delivery of babies, etc. BLS assessment includes brief and limited patient assessment and management procedures including evaluation of vital signs, mental and neurologic states, and hemodynamic stability.

B. Advanced Life Support (ALS): Advanced life support ambulance services include definitive medical treatment and complex specialized life sustaining procedures. Patient assessment is usually-complex and extensive, requiring frequent assessment of the vital signs, oxygenation, cardiac activity and hemodynamic status. Examples of advanced life support services are manual defibrillation/cardioversion, endotracheal intubation, cardiac pacing, chest decompression, insertion of central venous lines, administering life-sustaining drugs that are essential to, or that yields information that is essential to, the restoration or continuation of a bodily function important to the continuation of human life, and cardiopulmonary

resuscitation. Documentation must support the need for ALS services.

C. Appropriate Facilities: The facility/institution is generally equipped to provide the needed treatment for the patient's condition and is willing to accept the patient.

D. Bed Confined / Bedridden: Bed confined is defined as the inability to get up from bed without assistance, and inability to ambulate, and inability to sit in a chair, including a wheelchair. All three (3) of the above conditions must be met and will be applied to all transports. This term is used synonymously with the terms “bedridden” or “stretcher bound”. However, it is not synonymous with “bedrest” or “non-ambulatory”.

E. Medically Necessary Emergency Ground or Air Ambulance Service: To be considered as a medically necessary emergency for ground or air ambulance services, all three (3) of the following criteria must be met:

1. Ambulance (BLS or ALS) transport to the nearest hospital where treatment for an accidental injury or medical emergency is available,

2. The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and

3. The injury or medical emergency is sudden, of such severity that the absence of immediate medical care could reasonably result in permanently placing the patient's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

F. Medically Necessary Non-Emergency Ground: To be considered as medically necessary non-emergency for ground or air ambulance service, all three (3) of the following criteria must be met:

1. Ambulance transport to or from the nearest appropriate facility for the beneficiary to receive non-emergency medical care that cannot be provided in their place of residence or medical facility where the patient is an inpatient, and

2. The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and

3. The patient suffers from an injury or debilitated physical condition(s) that results in the patient being totally bedridden or bed confined.

G. Patient Loaded Mileage: The patient is on board the ambulance. Mileage to the point of pick-up, no patient on board, does not qualify as "patient loaded."

H. Medical Necessity: Medical necessity is established from the patient's condition at the time of transport, not the diagnosis. The patient's condition must be of such severity that the use of any other method of transportation is contraindicated or not possible. In cases where other

means of transportation could be utilized, the fact that there is no other means of transportation available does not justify medical necessity. In addition, if the patient is able to be transported by other means of transportation, but requires assistance from others in getting in or out of the other type of vehicle, the fact that such assistance is not available does not justify medical necessity.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.3: Reimbursement

Ambulance services will be reimbursed from a statewide uniform fixed fee schedule based on seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act), as amended.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.4: Documentation Requirements

A. Providers of ambulance services must satisfy all documentation and maintenance of records in accordance with Part 200, Chapter 1, Rule 1.3 and maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

1. Time and by whom the call was originated,

2. Diagnosis, if known, or nature of illness or injury,

3. Medical necessity clearly described,

4. For non-emergency ambulance services, the original Certificate of Medical Necessity, signed by the physician, nurse practitioner, or physician assistant must be kept on file at all times,

5. Patient's condition in detail which includes, but is not limited to, vital signs, level of consciousness, ability to sit/stand/walk, etc.,

6. Site of pick-up with address if known, time of pick-up, and recording of odometer reading, if air transport, site should be identified so that it can be located on a map,

7. Point of destination, time of arrival, and recording of odometer reading,

8. Detailed record of all services and treatment administered to the patient,

9. Documentation that the patient was taken to the closest appropriate facility or the reason that facility was unable to accept the patient that caused him/her to be taken to another facility,

10. Trip ticket must be included, and

11. Copies of prior approvals, when applicable.

B. Providers must maintain proper and complete documentation to verify the services provided.

Source: Miss. Code Ann. § 43-13-121; § 41-59-41

Rule 1.1.5: Mileage

A. The initial patient loaded twenty-five (25) miles are always included in the base rate and must not be billed separately to Medicaid. Odometer readings must be documented on the ambulance transport record. Odometer readings are defined as actual odometer reading rather than a number of miles.

B. Reimbursement for mileage will be allowed beginning with the twenty-sixth (26^{th}) patient loaded mile.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.6: Injectable Drugs

A. Ambulance providers must bill for injectable drugs, excluding solutions, using the appropriate procedure codes. Only the units actually administered are to be billed. The medical record must include documentation that substantiates the medical necessity of the drug.

B. Unused Injectable Drugs - If a portion of the drug in a single use or multiple dose use vial must be discarded, DOM will not reimburse for the discarded amount of the drug. Providers may not bill Mississippi Medicaid beneficiaries for the discarded drug.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.7: Ambulance Transport of Nursing Facility Residents by Ambulance

A. Medically necessary emergency and non-emergency ambulance transports to and from a nursing facility are covered. All medically necessary ambulance transports to and from a nursing facility must be billed by the ambulance provider.

1. The Ambulance Program policies apply to both emergency and non-emergency ambulance transports. This includes ambulance transport of Medicaid beneficiaries to and from dialysis treatments.

2. The nursing facility is responsible for arranging both emergency and non-emergency ambulance transports, including working with the ambulance providers to ensure that the

Certificate of Medical Necessity forms are completed in advance of the date that the ambulance transportation is required so that appointments do not have to be canceled due to no access to transportation. Beneficiaries must not be denied access to medical care because the nursing facilities have not arranged transportation in advance. The nursing home may not bill the beneficiary or family for covered ambulance transports.

B. Nursing Home Transports: If a beneficiary does not meet the coverage criteria for ambulance transportation through the Ambulance Program or non-emergency transportation through the NET Program, the nursing facility must arrange transportation through the family, if available, the nursing facility, or outside resources.

1. The cost for ambulance transports not covered through the Ambulance Program or the NET Program must be reported in the nursing facility cost report.

2. A nursing facility may ask the family to transport the beneficiary in a personal vehicle if the condition of the beneficiary allows that mode of transportation. However, if the family is not available or chooses not to transport the beneficiary, the nursing facility is responsible for arranging/providing transportation by use of nursing facility vehicles or through outside resources. The nursing facility may not require the family to transport the beneficiary, and the nursing facility may not bill the family for transportation by other means.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.53

Rule 1.1.8: Transport of Dual Eligibles

A. For beneficiaries covered under Medicare and Medicaid, dual eligibles, ambulance providers may file a claim with Medicaid for non-emergency ambulance services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity, like transport to a physician's office.

B. For ambulance transport to and from dialysis treatments, Mississippi Medicaid will only pay the deductible and coinsurance based on Medicare's allowed charges on cases approved by Medicare if the patient is covered by both Medicare and Mississippi Medicaid. If Medicare benefits are denied because (1) the patient is being taken to a non-approved dialysis facility or (2) the medical necessity criteria for ambulance transport is not satisfied, Medicaid will not approve benefits for the ambulance transport.

C. The six (6) month timely filing limitation for filing crossover claims is applicable with no exceptions.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.9: Non-Covered Services

Non-covered ambulance services include, but are not limited to, the following:

A. Transfer from a hospital that has appropriate facilities for treatment to another hospital.

B. Transportation of a deceased patient to a funeral home.

C. The beneficiary was pronounced dead prior to the time the ambulance was called. Pronouncement of death must be made by an individual who is licensed or otherwise authorized under State law to pronounce death in the State where such pronouncement is made.

D. Waiting time charges – the charge by an ambulance company for time spent while waiting for the patient.

E. The patient refused to be transported after the ambulance arrives in response to a call.

F. Separate charges for assessing the patient's condition or taking vital signs.

G. First-aid or other medical type treatment provided by ambulance staff to a patient who is not subsequently transported to the closest appropriate facility.

H. Non-injectable drugs and separate charges for intravenous solutions.

I. Separate charges for supplies and equipment.

J. Transportation of Medicare eligible patients to and from dialysis, except on crossover claims.

K. Non-emergency air transportation that has not been prior approved by the Division of Medicaid.

L. Mileage beyond the closest appropriate facility.

M. Charges for extra attendants such as EMT's, nurses, physicians, respiratory therapists, etc.

N. Transports for the convenience of the patient and/or family.

O. ALS or BLS emergency ambulance services and non-emergency ambulance services for which the medical necessity criteria have not been satisfied.

P. Transport of beneficiaries receiving Hospice benefits through Mississippi Medicaid.

Q. Services not specifically listed as covered services.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.10: Subscription Programs

Ambulance providers who offer subscription programs must be aware that the services offered in these programs are usually covered by Mississippi Medicaid, either through the Ambulance or through the Non-Emergency Transportation (NET) program. Selling a subscription to a Medicaid beneficiary could be interpreted as charging for the ambulance service. Providers must accept Medicaid payment as payment in full; therefore, there are no out of pocket expenses other than the ambulance co-payment per trip which is the responsibility of the beneficiary. Selling a subscription to cover co-payments could be interpreted as charging for a service not yet provided the Medicaid beneficiary.

Source: Miss. Code Ann. § 43-13-121

Rule 1.1.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Subchapter 2: Emergency (Ground/Air)

Rule 1.2.1: Emergency Ground Ambulance

A. To qualify as an Advanced Life Support (ALS) or Basic Life Support (BLS) emergency ambulance service, the trip must be:

   1. For patient loaded trips only,

   2. For medically necessary emergency services to the closest appropriate hospital for treatment, and

   3. In an appropriate ALS or BLS vehicle that has been licensed by the state.

B. Emergency ambulance providers are required to file all Medicaid claims on a CMS-1500 claim form. The provider must bill the appropriate ALS or BLS code applicable to the service rendered and the appropriate modifier to indicate origin and destination of the trip.

Source: *Miss. Code Ann.* §41-59-9

Rule 1.2.2: Multiple Patients/Arrivals

A. Multiple Patients - More than one (1) patient may be transported in one vehicle. When multiple patients are transferred in the same vehicle, the submitted charge must reflect the usual charge for one (1) patient divided by the number of patients on board. This is applicable to both the base and mileage charges.

B. Multiple Arrivals - When multiple units respond to a call for services, Mississippi Medicaid will only reimburse the unit that actually transports the patient.

Source: Miss. Code Ann. § 43-13-121

Rule 1.2.3: Air Ambulance

A. All air ambulance providers must be licensed in the state of Mississippi in order to transport a patient from one location to another within the state or from Mississippi to another state. Licensing is the responsibility of the Mississippi State Department of Health, Office of Emergency Medical Services.

B. Emergency Air Ambulance, or Helicopter - To qualify as an emergency air ambulance, or helicopter service, the trip must be:

1. For patient loaded trips only,

2. For medically necessary emergency services to the closest appropriate hospital for treatment, and

3. In an appropriate air ambulance, or helicopter.

C. Urgent Air Ambulance, Fixed Wing - To qualify as urgent air ambulance transport, the trip must be:

1. Prior approved by the Division of Medicaid,

2. For patient loaded miles only,

3. For medically necessary urgent services to the appropriate facility for treatment, and

4. In an appropriate fixed wing air ambulance.

D. If a request for urgent ambulance transport is received on Saturday or Sunday or on a holiday and the ambulance provider chooses to transport without prior approval, the provider may submit information to the Division of Medicaid on the next working day. In such cases, the Division of Medicaid will review the information on a retrospective basis and provide approval if all coverage criteria is satisfied.

E. Coverage is not available for patient or family preference or convenience. (Transport is not billable/reimbursable to a service not covered by Medicaid.)

Source: Miss. Code Ann. § 43-13-121; *Miss. Code Ann.* § 41-59-9

Subchapter 3: Non-Emergency

Rule 1.3.1: Non-Emergency Ground Ambulance

A. To qualify as non-emergency ambulance transport or for transport to a dialysis facility, the trip must be:

   1. For patient loaded miles only,

   2. For medically necessary non-emergency services to the appropriate facility for treatment, and

   3. In an appropriate ALS or BLS certified vehicle.

B. The fact that a patient is receiving intravenous fluids does not justify the medical necessity for ambulance transport. The patient's condition must be of such severity that ambulance transportation is justified.

C. The ambulance provider must obtain a Certificate of Medical Necessity (CMN) completed and signed by the attending physician, nurse practitioner, or physician assistant. The CMN form must be completed in detail, must describe all three (3) conditions that satisfy the criteria for non-emergency medical transportation, and must document the reason transportation by any other means is contraindicated. If the ambulance provider is unable to obtain the signed certification statement from the attending physician (MD), nurse practitioner (NP), or physician assistant (PA), a clinical nurse specialist (CNS), registered nurse (RN), or discharge planner (DC), who is employed by the hospital or facility where the beneficiary is being treated and who has knowledge of the beneficiary's condition at the time the transport was ordered, may complete and sign the Certification of Medical Necessity.

D. The original Certificate of Medical Necessity must be completed, dated, and signed prior to or within five (5) calendar days of the transport and must be kept on file by the provider and be available to the Division of Medicaid and/or its representatives for review at all times. If the ambulance provider's records do not contain the original Certificate of Medical Necessity, the provider may be asked to refund to the Mississippi Medicaid program any money received from the program for the service(s) provided. The Certificate of Medical Necessity is required to justify the medical necessity for the service(s) provided.

E. The original Certificate of Medical Necessity form will only be valid for sixty (60) days. For instances in which repetitive trips are required the Certificate of Medical Necessity form must be completed, dated, and signed every sixty (60) days upon reassessment of the patient's condition. These additional forms must also be retained in the ambulance provider's records.

Source: Miss. Code Ann. § 43-13-121; *Miss. Code Ann.* § 41-59-9; 42 CFR 431.53

Part 201 Chapter 2: Non-Emergency Transportation (NET) (Non-Ambulance)

Rule 2.1: NET Broker Program

A. The Division utilizes a NET Broker Program in order to provide Medicaid NET by means of appropriate vehicles to include wheelchair vans, taxis, minivans, sedans, and public transportation buses. The broker operates statewide and the broker determines the transportation provider who provides each transport. The most common mode of NET services is by ground vehicle. As with all Medicaid funded services, Medicaid NET services are available only as a last resort. Other non-Medicaid funded sources of non-emergency transportation services must be utilized first. Beneficiaries may not request transportation by a particular NET provider.

B. All drivers shall abide by state and local laws. All vehicles must adhere to federal, state, county or local requirements.

C. Requirements of the broker:

1. The broker is responsible for administering and operating the NET Broker Program, including but not limited to the authorization, coordination, scheduling, management, and reimbursement of NET services.

2. All NET Services must meet the following criteria:

a) The beneficiary is eligible for NET services.

b) The beneficiary has a medical need which requires NET services.

c) The most economical mode of transportation appropriate to meet the medical needs of the beneficiary are used, given the beneficiary's mobility status and personal capabilities on the date of service. The Broker shall document the reason in detail if broker approves a mode of transportation that is not the most economical.

d) The provider is the nearest appropriate provider to the beneficiary.

e) If an attendant or assistance requested is necessary. The Broker must require a medical certification statement from the beneficiary's physician.

f) The medical service for which NET service is requested is a covered medical service.

g) The beneficiary does not have access to available transportation.

h) The transport must be for a single covered medical service appointment.

i) The transport must be requested at least three (3) business days before the NET service is needed.

D. NET Authorizations:

1. Upon approval by the Division of Medicaid, the broker may deny the request if the covered medical service is available closer to the beneficiary's residence and a medical certification from a medical provider certifying that the beneficiary is unable to be treated at a closer facility is not obtained. The one exception to the medical certification requirement is transport to the University Medical Center, in Jackson, MS.

2. If a beneficiary has recently moved to a new area, the broker shall allow long distance transportation for up to ninety (90) days, if necessary, to maintain continuity of care until the transition of the beneficiary's care to a closer appropriate provider can be completed. The Broker shall monitor the frequency of authorizations of NET services involving excessive distance per beneficiary.

3. The broker must perform post-transportation authorization in instances when prior authorization was not obtainable.

E. Reporting

1. The broker and NET providers are responsible for reporting to the Division of Medicaid any beneficiary who accuses his/her driver or other passengers of sexual harassment or physical abuse. Medicaid beneficiaries should report any incident of abuse or sexual harassment directly to the broker. State law requires that all suspected physical abuse of drivers, beneficiaries, and other passengers be reported to the Department of Human Services (DHS).

2. The broker must refer suspected fraud, abuse, or misuse by beneficiaries, NET providers, providers, or broker staff to the Division of Medicaid's Bureau of Program Integrity within three (3) business days after discovery of the suspected fraud, abuse, or misuse.

3. The broker must document accidents and incidents that occur in conjunction with a scheduled trip when a beneficiary is present in the vehicle and must be reported within seventy-two (72) hours of the accident/incident.

F. Meals and Lodging

1. Meals for day trips are not reimbursable under the NET program.

2. When the medical service required by a beneficiary is available only in another county, city, or state, travel time and distance may warrant staying overnight. Related travel expenses may include overnight lodging and meals for eligible beneficiaries and their attendants while in transit to and from the medical resource.

3. In certain situations, a Medicaid beneficiary must be fed and housed while he/she is receiving medical treatment in a facility that does not provide room and board.

4. If a beneficiary must be attended during the transport, an attendant may be transported

with the beneficiary provided that:

a) Travel by the attendant with the beneficiary is prior approved by the Broker.

b) The need by the beneficiary for an attendant is certified as medically necessary by the beneficiary's attending medical provider, and

c) The attendant scheduled to assist the beneficiary is qualified to provide the kind of assistance required by the beneficiary.

5. The beneficiary's medical provider must complete a medical certification form specifying that the beneficiary required an attendant and the type of assistance the attendant is to provide to the beneficiary.

6. The Broker will pay limited costs for an attendant to accompany a beneficiary during transport. These costs include transportation and/or salary. The Broker will pay the cost of an attendant to accompany a beneficiary during transport only when a separate ticket must be purchased in order for the attendant to provide the required assistance to the beneficiary. No other costs associated with the attendant's travel will be paid by the Broker. Salary expense for an attendant may be paid only if the attendant is specifically trained to provide care required by the beneficiary due to the beneficiary's medical condition. Under no condition may salary expense be billed if the attendant is a member of the beneficiary's family. All costs associated with attendant care for a beneficiary must be documented with receipts. Meals are not covered for a day trip when an overnight stay is not required.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.53; 42 CFR § 440.170(a)(1) and (3) – (4); 42 CFR 440.170(a)(4)

Rule 2.2: Eligibility

A. In order to be eligible for NET services, a beneficiary must be currently eligible to receive Medicaid services. Beneficiaries in the following Categories of Eligibility are not eligible to receive NET services:

1. Family Planning

2. Qualified Medicare Beneficiary (QMB)

3. Specified Low-Income Medicare Beneficiary (SLMB)

4. Qualified Individual (QI-1)

B. NET services are covered for eligible beneficiaries when the beneficiary:

1. Requires the services covered by Medicaid from a Medicaid approved provider,

2. Has no other means of getting to and/or from the provider for a Medicaid covered service,

3. Has not exceeded any service limits associated with the covered service, and

4. Has not received transportation services to medical services from any other source.

C. Medicaid may not require beneficiaries to arrange their own NET services unless the medical service they require is not covered by Medicaid.

D. A beneficiary may request that a family member or friend serve as their attendant during a transport. The broker must require that the need for an attendant be verified by a written medical certification from the medical provider. In addition, medical certification may be required if the beneficiary is requesting transportation other than to the nearest appropriate provider. All transports by public air will require written certification.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.53

Rule 2.3: Non-Covered Services

A. If requests for NET services falls under one (1) or more of the criteria listed below, broker will deny the request system and document the reason for the denial on the same business day. Broker must mail denial letters to beneficiaries no later than the next business day following the date the denial decision was made. The denial letter shall notify the beneficiary of their right to appeal the denial. The Division of Medicaid, in its sole discretion, may add, modify, or delete denial reasons without additional payment to broker or a contract amendment.

B. Non-covered services include:

1. The beneficiary is not eligible for NET services on the date of service.

2. The beneficiary does not have a medical need that requires NET services.

3. The medical service for which NET service is requested is not a covered medical service.

4. The beneficiary has access to available transportation.

5. Transportation to the medical service for which NET service is requested is covered under another program.

6. The request was for post-transportation authorization was not received timely nor did it meet established criteria.

7. The medical appointment is not scheduled or was not kept.

8. Broker cannot confirm that there was a medical appointment.

9. The trip was not requested timely and the request cannot be accommodated because of this.

10. Additional documentation was requested and was not received timely.

11. The beneficiary refuses the appropriate mode of transportation, or

12. The beneficiary refuses the NET provider assigned to the trip and another appropriate NET provider is not available.

Source: Miss. Code Ann. § 43-13-121

Rule 2.4: Transport of Nursing Facility Residents by NET

A. All transportation for nursing facility residents for non-emergencies must be arranged by nursing facility staff. Beneficiaries must not be denied access to medical care because nursing facility staff did not arrange transportation in advance.

B. Costs for providing this level of service are to be reported by the nursing facility on their cost reports and are reimbursed through the facility per diem. The nursing facility may not require the family to transport the beneficiary and the nursing facility may not bill the family nor the resident for transportation.

C. Transportation to a hospital and transportation from the hospital is arranged through the nursing facility.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.53

Rule 2.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121