New Hampshire Medicaid
AMBULANCE PROVIDER REFERENCE GUIDE

This guide clarifies routine, emergency and facility transfer ambulance coverage for New Hampshire Medicaid health plan and Fee-for-Service (FFS) beneficiaries.

Scheduled Routine Transportation (Broker)

Non-emergency ambulance transportation for Medicaid-covered services is **scheduled in advance** and coordinated through contracted transportation **brokers** described in the Quick Summary Guide. Completion of a beneficiary Mobility Form is required to ascertain ambulance transport medical necessity.

Non-emergency ambulance transportation for Medicaid-covered services is billable to the beneficiary's Medicaid health plan or FFS transportation broker, including:

- **Scheduled and routine** appointments for Medicaid- covered services;
- **Discharges** from a healthcare facility to residence*

Non-emergency ambulance transportation providers must be contracted with the beneficiary's Medicaid health plan or FFS transportation broker to be reimbursed.

Note: ***Under federal law, the NH Medicaid program is the payer of last resort.***

Facility Transfers (Health Plan)

Ambulance transfer services are scheduled by the hospital directly with the ambulance provider. No prior authorization or advance notice is required:

- from an **acute care hospital ED to an in-patient psychiatric facility** for admission - billable to the beneficiary's Medicaid health plan or FFS.
- for Medicaid-covered services between healthcare settings, including scenarios such as **between two acute care hospitals or an acute care hospital to rehabilitation facility** when the necessary treatment or diagnostic service cannot be provided by the originating hospital, as applicable:
  - Beneficiary is **discharged**—service is billable to the beneficiary's Medicaid health plan or FFS.
  - Beneficiary is **not discharged**—service is billable to the originating facility (e.g., DRG reimbursement)

Emergency Transportation (Health Plan)

Emergency ambulance transportation services are for emergency medical conditions. Ambulance providers can be contacted directly for emergencies. No prior authorization or advance notice is required. These services are not coordinated through contracted brokers. These services are billable to the beneficiary's Medicaid health plan or FFS.

Examples of Transport Scenarios:

- *Scenario A:* A Medicaid member, who is a **resident at a nursing facility**, has an accident and needs to be taken to the **emergency room** in the middle of the night. The ambulance is called by the nursing facility to bring the resident to the ER. The resident is evaluated and treated but not admitted. The resident can return to the facility.*

  Coverage: The **trip to the ED is emergency**. It is coordinated directly between the facility and the ambulance company and is billed directly to the beneficiary's Medicaid health plan or FFS as a covered service as outlined in the NH Medicaid Ambulance Provider Manual.

  The **return trip is non-emergency transport**. The facility should first contact the broker (via the after-hours number, phone message, or broker portal) and then contact the transportation company for the transport via the most appropriate vehicle type. These trips are billed to the beneficiary's Medicaid health plan broker or FFS broker as non-emergency transportation. Please use the Quick Summary Guide for reference. Members who require an ambulance for transportation are identified using the Mobility Form.

- *Scenario B:* A Medicaid member is **discharged to their home* from an inpatient hospital stay**.

  Coverage: This is a **non-emergency transport**. The facility should contact the broker to have the broker secure the transport via the most appropriate vehicle type. These trips are billed to the beneficiary's Medicaid health plan or FFS broker. Please use the Quick Summary Guide for reference. Members who require an ambulance for transportation are identified using the Mobility Form.

- *Scenario C:* A Medicaid member is **admitted to the hospital for treatment**. The member needs a diagnostic service that cannot be provided by the facility, but can be completed at a nearby hospital. The member is transported to the nearby hospital to receive the test and then returned to the original facility. The **member was not discharged** from the original facility.

  Coverage: These services are covered under the DRG of the hospital and are payable by the hospital. Please refer to the NH Medicaid Ambulance Provider Manual (non-covered services).

- *Scenario D*: A Medicaid member is **admitted to the hospital after an accident**. The facility determines that they do not have the resources needed to appropriately treat the member for the injuries sustained. The member is **discharged from the hospital and transported to a different facility** that is better equipped to treat the member.

  Coverage: This transport is covered by Medicaid as a transportation service and billed directly to the beneficiary's Medicaid health plan or FFS, as outlined in the NH Medicaid Ambulance Provider Manual.

  **Covered services include transportation to any Medicaid covered service, regardless of where the member resides (e.g. home, nursing facility). Residence/home is considered the address listed on the eligibility file. Transports to or from an address other than the one listed in the eligibility file require prior approval.*