**RULE**

**Department of Health**
**Bureau of Health Services Financing**

**Emergency Medical Transportation Services**
**Ambulance Licensing Standards**
**(LAC 48:I.6037)**

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.6037 in the Medical Assistance Program as authorized by R.S. 36:254, R.S. 40:1133.14 and R.S.40:1135.3. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

**Title 48**
**PUBLIC HEALTH—GENERAL**
**Part I. General Administration**
**Subpart 3. Licensing and Certification**

**Chapter 60. Emergency Medical Transportation Services**

**Subchapter B. Provider Responsibilities**

**§6037. Medical Protocol**

A. – C.21. ...

D. The EMS service shall adopt the protocols established by the Louisiana Emergency Response Network (LERN) or develop an agency specific protocol with specific language related to the transportation of the following patients:

1. Acute stroke patients shall be transported to the closest appropriate primary stroke center, acute stroke ready hospital, or closest appropriate hospital if the patient

exhibits a compromise of airway, breathing or circulatory function, or other potential life threatening emergency as defined by the protocols implemented by the ambulance service's medical director. Acute stroke patients may also be diverted to the closest appropriate hospital by order of LERN or online medical control from the local facility, potential receiving facility or medical director.

2. ...

3. In any case where the treating emergency medical technician's evaluation, according to protocol, indicates a potentially unstable condition or potential medical emergency that, if traveling the extra distance to the recommended appropriate facility could put the patient at higher risk, the emergency medical technician in his/her discretion may divert to the nearest appropriate facility.

E. – E.4. ...

F. Ambulance services are accountable for assuring compliance with applicable protocols by their personnel. Exceptions to these protocols must be reviewed on a case-by-case basis by the physician medical director.

1. Treatment decisions shall be considered given the current health status of the patient in conjunction with all of the associated risks factors including, but not limited to, distance to the nearest stroke facility.

G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1133.14 and 40:1135.3.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:476 (March 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2153 (October 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

Rebekah E. Gee MD, MPH

Secretary

**RULE**

**Department of Health**
**Bureau of Health Services Financing**

**Medicaid Eligibility**
**Federally-Facilitated Marketplace Determinations**
**(LAC 50:III.505)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.505 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**
**Part III. Eligibility**
**Subpart 1. General Administration**

**Chapter 5. Application Processing**

**§505. Federally-Facilitated Marketplace Determinations**

A. Effective April 20, 2016, Louisiana Medicaid will delegate its Medicaid eligibility determination authority to the federally-facilitated marketplace (FFM) in order to begin accepting eligibility determinations made by the FFM for only those individuals who apply for healthcare coverage through the FFM. This action will result in the state becoming a determination state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1489 (August 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

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**RULE**

**Department of Health**
**Bureau of Health Services Financing**

**Medical Transportation Program**
**Non-Emergency Medical Transportation**
**(LAC 50:XXVII:Chapter 5)**

The Department of Health, Bureau of Health Services Financing has repealed and replaced the provisions of the October 20, 1994 Rule governing non-emergency medical transportation, and amended LAC 50:XXVII.Chapter 5 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**
**PUBLIC HEALTH—MEDICAL ASSISTANCE**
**Part XXVII. Medical Transportation Program**

**Chapter 5. Non-Emergency Medical Transportation**

**Subchapter A. General Provisions**

**§501. Introduction**

A. Non-emergency medical transportation (NEMT) is non-emergency transportation to and from the providers of routine Medicaid covered services for Medicaid recipients. NEMT is intended to provide transportation only after all reasonable means of free transportation have been explored and found to be unavailable.

B. Medicaid covered transportation is available to Medicaid recipients when:

1. the individual is enrolled in either a full-coverage Medicaid benefit program or a limited-coverage Medicaid benefit program that explicitly includes transportation services; and

2. the recipient or their representative has stated that they have no other means of transportation.

C. The requested destination must be to a medical or behavioral health service provider currently enrolled in the Medicaid Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§503. Prior Authorization**

A. NEMT services require prior authorization. The department or its designee will authorize transportation after verifying the recipient's Medicaid eligibility and validity of medical or behavioral health appointment(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§505. Requirements for Coverage**

A. When transportation is not available through family and friends, payment shall be authorized for the least costly means of transportation available. The least costly means of transportation shall be determined by the department and shall be determined according to the following hierarchy:

1. city or parish public transportation;

2. family and friends who meet the state license and insurance requirements and who are willing to:

a. enroll in the Medicaid Program; and

b. be paid a published rate for providing non-emergency transportation;

3. intrastate public conveyance (such as bus, train or plane);

4. nonprofit agencies and organizations that provide a transportation service and who are enrolled in the Medicaid Program; and

5. for profit providers enrolled in the Medicaid Program.

B. Recipients shall be allowed a choice of providers when the costs of two or more providers are equal.

C. Recipients are encouraged to utilize medical or behavioral health providers of their choice in the community in which they reside when the recipient is also in need of Medicaid

reimbursed transportation services. The fact that the department will still pay for the actual medical or behavioral health service received outside the community in which the recipient resides does not obligate the department to reimburse for transportation to accommodate such a choice.

D. When the recipient chooses to utilize a medical or behavioral health provider outside of the community due to preference and/or history, payment may be authorized only for the cost of transportation to the nearest available provider.

E. The recipient may be responsible for securing any agreements with family and friends, nonprofit or profit providers to make the longer trip for the payment authorized. If the recipient needs help with making such arrangements, the department will help but the help given will imply no obligation to provide a greater reimbursement.

F. When specialty treatment required by the recipient necessitates travel over extended distances, authorization for payment for intrastate transportation shall be determined according to the following criteria.

1. Intrastate transportation reimbursement shall be authorized when medical or behavioral health services are not available to the recipient in his/her community.

2. Payment shall be authorized when free transportation is not available.

3. The department shall still authorize payment only for the most economical means of transportation. This may be through negotiating payment for transportation with family and or friends or through accessing the public conveyance systems such as bus, train or plane.

4. The determination as to use of public conveyance shall be based on least cost, medical or behavioral health condition of the recipient to be transported, and availability of public conveyance.

G. When it has been verified that public conveyance is unavailable or inappropriate for intrastate transportation the recipient shall solicit transportation from family and friends. The department will authorize payment to assist the family in accessing the needed medical services.

1. Payment will be based on distance to be traveled to the nearest available similar or appropriate medical or behavioral health services, parking and tolls. In determining the amount of payment the cost of the least costly public conveyance shall be used as the base cost to be paid to the family. Payment shall not be available for room and board or meals.

H. When no other means of transportation is available through family and friends or public conveyance, the department

will solicit intrastate transportation through a nonprofit provider.

1. The nonprofit provider will be paid a fee based on the current fee schedule.

2. If the nonprofit provider cannot accept the trip then the department will reimburse for-profit providers based on the current fee schedule.

I. The department will not authorize "same day" trips except in the instance of need for immediate medical care due to injury or illness. Same day trips will not be authorized for scheduled appointments for predictable or routine medical or behavioral health care. Recipients will be asked to reschedule the appointment and make the subsequent request for transportation timely.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**Subchapter B. Recipient Participation**

**§521. General Provisions**

A. Recipients shall participate in securing transportation at a low cost and shall agree to use public transportation or solicit transportation from family and friends as an alternative to more costly means of transport.

B. When the recipient alleges that public conveyance cannot be used due to medical reasons, then verification shall be provided by giving the department a written statement from a doctor that includes the specific reason(s) that the use of public conveyance is contraindicated by the medical or behavioral health condition of the recipient. In no case can preference of the recipient be the sole determining factor in excluding use of public conveyance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§523. Recipient Appeals**

A. Recipients shall have a right to request a fair hearing for the denial of NEMT services in full or in part. This includes requests for a fair hearing for denial of meals and lodging expenses associated with authorized trips.

B. Recipients shall be provided written notice of the service denial (including denials for meals and/or lodging expenses) and given the opportunity to request a fair hearing to appeal the department’s decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**Subchapter C. Provider Responsibilities**

**§541. Provider Enrollment**

A. All transportation providers must comply with the published rules and regulations governing the Medicaid Transportation Program, all state laws, and the regulations of any other governing state agency or commission or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid Program.

B. Non-emergency medical transportation profit providers shall have a minimum liability insurance coverage of $100,000 per person and $300,000 per accident or a $300,000 combined service limits policy.

1. The liability policy shall cover any and all:

a. autos;

b. hired autos; and

c. non-owned autos.

2. Premiums shall be prepaid for a period of six months. Proof of prepaid insurance must be a true and correct copy of the policy issued by the home office of the insurance company. Statements from the agent writing the policy will not be acceptable. Proof must include the dates of coverage and a 30-day cancellation notification clause. Proof of renewal must

be received by the department no later than 48 hours prior to the end date of coverage. The policy must provide that the 30-day cancellation notification be issued to the Bureau of Health Services Financing.

3. Upon notice of cancellation or expiration of the coverage, the department will immediately cancel the provider agreement for participation. The ending date of participation shall be the ending date of insurance coverage. Retroactive coverage statements will not be accepted. Providers who lose the right to participate due to lack of prepaid insurance may re-enroll in the transportation program and will be subject to all applicable enrollment procedures, policies, and fees for new providers.

C. As a condition of reimbursement for transporting Medicaid recipients to medical or behavioral health services, family and friends must maintain the state minimum automobile liability insurance coverage, a current state inspection sticker, and a current valid driver's license. No special inspection by the department will be conducted. Proof of compliance with the three listed requirements for this class of provider must be submitted when enrollment in the department is sought. Proof shall be the sworn and notarized statement of the individual enrolling for payment, certifying that all three requirements are met. Family and friends shall be enrolled and

shall be allowed to transport up to three specific Medicaid recipients or all members of one Medicaid assistance unit. The recipients to be transported by each such provider will be noted in the computer files of the department. Individuals transporting more than three Medicaid recipients shall be considered profit providers and shall be enrolled as such.

D. As a condition of participation for out-of-state transport, providers of transportation to out-of-state medical or behavioral health services must be in compliance with all applicable federal intrastate commerce laws regarding such transportation, including but not limited to, the $1,000,000 insurance requirement. Proof of compliance with all interstate commerce laws must be submitted when enrollment in the Medicaid Program is sought or prior to providing any out-of-state Medicaid transportation.

E. A provider must agree to cover the entire parish or parishes for which he provides non-emergency medical transportation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§543. Trip Coordination**

A. Dispatch personnel will coordinate to the extent possible, trips for family members so that all recipients in a family are transported as a unit at one time to the same or close proximity providers.

B. Providers must submit a signed affidavit with claims certifying that a true and correct bill is being submitted.

C. If the provider has declined to accept a trip on a particular day the dispatch personnel will not assign additional trips to that provider for that same day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§545. Provider Suspension and Termination**

A. Providers are subject to suspension from the NEMT Program upon department documentation of inappropriate billing practices or other practices that egregiously violate Medicaid Program policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§547. Audits**

A. The department shall conduct regular audits of service authorization, reimbursement, service delivery and documentation in order to ensure compliance with published rules and regulations.

B. Lack of compliance on the part of transportation providers shall be addressed as described in the provider policy manual.

C. Lack of compliance on the part of department contractors shall be met with corrective action as described in contract documents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**Subchapter D. Reimbursement**

**§565. General Provisions**

A. Reimbursement for NEMT services shall be based upon the current fee schedule. An additional per-mile rate may be included when the department determines that a provider requires compensation for travelling far outside of their service areas. This additional payment shall be made when there are no providers in the recipient’s service area

B. Reimbursement for NEMT to regular, predictable and continuing medical services, such as hemodialysis, chemotherapy

or rehabilitation therapy, as determined by the department, shall be based on a capitated rate paid by individual trip.

C. Reimbursement will not be made for any additional person(s) who must accompany the recipient to the medical provider.

D. An individual provider will be reimbursed for a trip to the nearest facility that will meet the recipient's medical or behavioral health needs. However, the individual provider may transport the recipient to a more distant facility if the individual provider will accept reimbursement from the department to the nearest facility and assumes responsibility for additional expenses incurred.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 42:

**§573. Non-Emergency, Non-Ambulance Transportation**

A. - F.5. ...

G. Effective for dates of service on or after October 1, 2014, the monthly payment of capitated rates shall be replaced with a per trip payment methodology.

1. Payments previously made using the monthly capitated rate shall be made by dividing the monthly rate by the

number of authorized trips within a given month. Each trip will then be reimbursed separately.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:462 (March 2007), LR 34:878 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2564 (November 2010), LR 37:3030 (October 2011), amended LR 38:3214 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

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