Comments for Chapter 524 Transportation

Effective Date 9/18/15

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
1	7/14/15	In regards to the Broker, we would like the manual to reference what to do when the Broker fails to pick up the patient and a non-contracted agency provides the transport. Is this WV Medicaid, patient or Broker responsibility?	**NC**		The Broker does not transport members. If one of the Broker's contracted transportation providers fails to pick up a member the Broker will arrange another transport or offer the member gas mileage reimbursement. The Broker may apply liquidated damages to the transportation provider for deficient performance per contract requirements. The only reason a provider that does not have a contract with the Broker would provide transport in the situation described is that the member met medical necessity criteria for that transport, such as stretcher

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					transport. In that case, the trip would be billed to Medicaid. Providers are not permitted to bill members for Medicaid covered services.
2	7/14/15	In regards to section 524.2.7, Limitations and Special Circumstances, that WV Medicaid covers ambulance services subject to the following limitations, conditions, and special circumstances: • Ground ambulance must transport the member to the nearest facility that has appropriate equipment and personnel, necessary to diagnose and treat the member. We were told by the transportation Director that the nearest facility is applied to	**C**	Admissions and readmissions to nursing facilities and other extended care facilities are exempt from this requirement.	BMS changed by adding clarifying language at the end of the bullet.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		hospital to hospital transports and not discharges to Skilled Nursing or Extended Care facilities where the patients were new admits to these facilities. We run into this a lot with discharges from Ruby as Medicare states they have to go to the closest SNF from the discharging hospital. We understand that the Medicaid member can be transported to any SNF regardless of new admission or a return as long as medical necessity is met.			
3	7/14/15	Since chapter 524 is being rewritten now, is there any possibility to increase non-emergent ambulance transportation reimbursements? $90 Pickup and $3.80 a mile is less than half of what Medicare pays.	**NC**		Rates will not be increased at this time.
4	7/20/15	What is the broker's mileage reimbursement rate required	**C**	Mileage will be reimbursed by the	BMS changed the language in Section 524.3.2.3.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		with member NEMT reimbursement?		broker for the shortest route as determined by the Broker at the current state rate.	In response to question the current state rate is 57.5 cents per mile effective July 1, 2015, in accordance with the West Virginia State Travel Rules for privately-owned vehicles to adhere to the federal government rate set by the United States General Services Administration (GSA). The rate amount will not be added to the Policy.
5	7/24/15	524.1.3 Ongoing Compliance and 524.2.2 Ground Ambulance **The guidance provided in 524.1.3 and 524.2.2 Conflicts and should be revised For consistency.**	**C**	Records and documentation that fully disclose the type, level, and volume of services provided must be maintained in accordance with State and Federal	BMS changed the language in Section 524.1.3 for clarity.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		524.1.3 addresses retention of records and requires records and documentation that fully Disclose the type, level, and volume of services provided must be maintained for 6 years from the date of service and made available upon request to BMS. Our organization questions why BMS is requiring extensive documentation be retained and accessible for 6 years when 524.2.2 states, "If a post payment review is conducted, decisions will be based on the documentation on the patient care record. This document must stand alone to justify billing. Supporting information regarding the patient's status gathered after the fact will not be considered in the review process." This stand---alone policy is substantially		requirements and documentation requirements in Chapter 100 General Administration and Information and Chapter 300 Provider Participation Requirements.	

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		more restrictive than Medicare policy and appears to be discriminatory towards ground ambulance providers as other contracted medical providers are permitted to provide additional information to Medicaid to support claims. We would request that BMS adopt the documentation requirements contained in Medicare Benefit Policy Manual Chapter 10 Ambulance Services. This policy states in 10.2.4 Documentation Requirements, "in all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier." This same approach to documentation is stated in 10.2.1 Necessity for the Services which states,			

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		"Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services."			
6	7/24/15	524.2 Ambulance Services **The covered ambulance services list should be expanded to include Critical Care Transport.** Critical Care Transport or Specialty Care Transport (SCT) is a level of service recognized by CMS. Since the last update to the transportation manual in	**NC**		BMS is not adding covered transportation services at this time. Reflecting this decision no new codes or modifiers will be covered. However, BMS appreciates the commenter's interest and will take these suggestions under advisement for possible coverage at a later date.

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		2003, the Office of Emergency Medical Services within West Virginia's Department of Health and Human Resources has extended certification to Critical Care Transport. This highly specialized level of care requires staffing, equipment and medical supplies that far exceed those of Advanced Life Support and these higher---level medical services should be recognized by the Medicaid program. The Medicare Benefit Policy Manual Chapter 10 – Ambulance Services provides the following definition and application for Critical Care Transport/Specialty Care Transport: ***Specialty Care Transport (SCT)*** ***Definition:*** *Specialty care transport (SCT) is the*			

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		interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professional in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training. ***Application:*** *The EMT-Paramedic level of care is set by each State. SCT is necessary when a beneficiary's condition requires ongoing care that must be*			

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		furnished by one or more health professionals in an appropriate specialty area. Care above that level is that is medically necessary and that is furnished at a level of serve above the EMT-Paramedic level of care is considered SCT. That is to say, if EMT-Paramedics – without specialty care certification or qualification – are permitted to furnish a given service in a State, then that service does not qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a State may permit a person who is not only certified as an EMT-Paramedic but who also has successfully completed additional education as determined by the State in furnishing higher level medical services required by critically ill or critically injured patients, to furnish a level of			

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		service that otherwise would require a health professional in an appropriate specialty care area (for example a nurse) to provide. "Additional training" means the specific additional training that a State requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or critically injured patient during an SCT.			
7	7/24/15	**Covered ambulance services should also be expanded to include and facilitate community paramedicine.** Community Paramedicine (CP) is a model of community---based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more	**NC**		BMS is not adding covered transportation services at this time. Reflecting this decision no new codes or modifiers will be covered. However, BMS appreciates the commenter's interest and will take these suggestions under advisement for possible coverage at a later date.

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		appropriate use of emergency care resources and enhance access to primary care for medically underserved populations. CP programs typically are designed to address specific local problems. Interest in community paramedicine has substantially grown in recent years based on the belief that it may improve access to and quality of care while also reducing costs. Community Paramedicine focuses on providing services, where access to care is limited, or a short term intervention is needed. By targeting locally identified health care needs, and offering a creative solution to fill local health care gaps, CP helps to increase access to care, and often reduces health care			

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		costs by providing the right level of care based on the individuals medical needs. North Carolina, Colorado, Minnesota, Maine, and Texas have implemented variations of community paramedicine. These programs have demonstrated that paramedics can be trained to safely and effectively perform an expanded role, with cost savings. A sample definition for Community Paramedicine is provided below: A Community Paramedic (CP) is a certified paramedic who has additional training in physiology, disease processes, injury and illness prevention, and medical system navigation. By design, the Community			

Comments for Chapter 524 Transportation

Effective Date 9/18/15

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		Paramedic is intended to be a provider of public health services to the elderly, underserved, and chronic condition-patient populations by providing primary care as an extension of a physician, while acting as the patient's advocate to connect them to a variety of beneficial social services outside the emergency department or hospital. Community Paramedics provide health assessment, chronic disease monitoring and education, medication care and prescription regime compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.			

Comments for Chapter 524 Transportation

Effective Date 9/18/15

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
8	7/24/15	**Non---emergency ambulance prior authorization** Page six under 524.2 Ambulance Services states, "Non-emergency ambulance transportation is subject to prior authorization by the BMS' utilization management contractor (UMC)." The ambulance provider community is unaware of prior authorization process or BMS contractors for non-emergency ambulance transportation. If such a process or contractor exists or will be implemented in the immediate future, we would requests additional information	**C**	Non-emergency ambulance transportation **may be** subject to prior authorization by the BMS' utilization management contractor (UMC).	The BMS changed the language in Section 524.2 BMS may decide to prior authorize this service in the future. If this is the case, appropriate and timely notification will be sent to all affected providers.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		that we can share with members to ensure compliance with the requirements of the BMS transportation manual.			
9	7/24/15	524.2.3 Paramedic Intercept (PI) **The application of Paramedic Intercept is unfair and harmful to small agencies.** Paramedic intercept is an important and widely used service particularly in West Virginia's most rural counties. Due to low population density, topography and difficulty recruiting and retaining paramedics, maintaining 24-	**NC**		BMS is not adding covered transportation services at this time. Reflecting this decision no new codes or modifiers will be covered. However, BMS appreciates the commenter's interest and will take these suggestions under advisement for possible coverage at a later date.

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		hour emergency Advance Life Support (ALS) service is not feasible in some areas of the state. These communities and the squads servicing them frequently can only sustain Basic Life Support services. In these cases, the squads often rely on paramedic intercept by another agency to deliver ALS care to their patients. The policy as currently drafted does not permit a rural squad that delivers BLS services and transports a patient many miles before transferring the patient to an ALS unit in another county to receive any payment. These rural squads have performed an otherwise covered service to the beneficiary but are penalized for transitioning the patient to a more			

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		appropriate level of care that was not previously available in an emergency environment. This policy that requires rural BLS squads to provide all of the care or receive no reimbursement discourages the use of paramedic intercept and appears discriminatory towards ambulance providers when other medical providers that transfer patients to a more appropriate facility for care are compensated for their services. We would ask this policy be modified to allow squads that deliver covered BLS services to an eligible Medicaid beneficiary to receive some level of reimbursement when			

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		a patient is transferred to another squad by paramedic intercept to receive ALS services. Under this circumstance both providers are delivering covered services and should be compensated appropriately. Considering that the current Molina claim adjudication process disallows any HCPCS with the modifier "RS" or "SS", a plausible solution would be to allow the addition of a "T" modifier, not currently in use when in the presence of the A0429 HCPCS only. This would be specific for ground transfer locations utilized for ALS intercept of BLS units. Thus, ambulances staffed with a BLS crew that responded to either a residence or scene and that require intercept by ALS or			

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		other higher levels would be permitted to receive reimbursement for their BLS--- Emergency load fee and mileage up to the point of intercept. Alternately, set the software to allow both the "RS" and the "SS" in the presence of the A0429 HCPCS only. Additionally, utilizing the second modifier "GT" to indicate ground transfer site. Again, this would allow reimbursement to the BLS service provider for their work up to the site of transfer. The option of using the existing "I" modifier was explored but fearing confusion with transfers to air providers and possible misuse, a more definitive set of modifiers would			

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		allow for greater specificity in describing pick up locations			
10	7/24/15	524.2.7 Limitations and Special Circumstances The first bullet in this section states, "ground and air ambulances must transport the member to the nearest facility that has the appropriate equipment and personnel necessary to diagnose and treat the member." This policy provides no exceptions for facilities being on diversion, mass casualty and injury situation, weather or other events that may make it inappropriate to transport a patient to the nearest facility. We would suggest	**C**	Ground and air ambulances must transport the member to the nearest facility that has the appropriate equipment and personnel necessary to diagnose and treat the member unless documented that transport to the nearest facility was inappropriate due to instruction by medical command, weather or other circumstances to make transfer to another facility more appropriate for patient care.	BMS changed the language in Section 524.2.7

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		the language be amended to read: *Ground and air ambulances must transport the member to the nearest facility that has the appropriate equipment and personnel necessary to diagnose and treat the member unless documented that transport to the nearest facility was inappropriate due to instruction by medical command, weather or other circumstances to make transfer to another facility more appropriate for patient care.*			
11	7/24/15	524.2.7 Limitations and Special Circumstances We are also concerned about the second bullet that states, "Ambulance transportation from one hospital to a more distant hospital must be for specialized medical care that is not available	**NC**		BMS believes the statement is appropriate as written. Ambulance drivers are not required to determine necessity for interhospital transfers.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		at the first hospital." EMS personnel are certified not licensed and practice under the license of a medical director. Policies such as this require EMS personnel to judge the availability of services at a particular facility and potentially challenge the orders of a physician. We believe it is inappropriate to place ambulance squads between a physician and their order that directs a patient's care. Decisions related to the appropriate transfer of patients should be made by the physician and transferring facilities and should not reside with the ambulance squad.			
12	7/24/15	524.3.2.1 Specialized Multi-Passenger Van Transport (SMPVT) The heading and	**C**		BMS changed the terminology in the header and throughout the section from "Specialized Multi-Passenger Van Transport

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		definition contained within this section addresses Specialized Multi-Passenger **Van** Transport. However, the first sentence of the section uses the term "Specialized Multi-Passenger **Medical** Transport". This section should be modified to read as follows: "Providers of Specialized Multi-Passenger Medical Van Transport services transport "			(SMPVT)" to "Specialized Multi-Patient Medical Transport (SMPMT)."
13	7/24/15	524.3.5 Residential Facility Transportation Services This section states that "emergency transportation" must be provided by the	**C**	524.3.5 Psychiatric Residential Treatment Facilities (PRTF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)Transportation	BMS changed Section 524.3.5 heading to specify the types of Residential Facilities BMS also added additional language to Section 524.3.5 for clarity.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		facility. We believe this needs further clarification so "emergency transportation" is not confused with emergency medical transportation which is reimbursed by Medicaid.		Services Transportation of members to and from medical appointments, court appearances, day habilitation, and transportation to family visits must be provided by the facility. It is considered included in the per diem rate and not separately reimbursable. West Virginia Medicaid reimburses separately for emergency transportation services rendered to members residing in PRTFs and ICF/IID facilities when the services are medically necessary.	
14	7/24/15	524.4 Reimbursement and Billing	**C**	Ambulance services are reimbursed directly by	BMS agrees with the commenter and added the

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		This section state that "Ambulance services are reimbursed directly by Medicaid and must be billed on CMS 1500 forms using the appropriate procedure codes and modifiers. This language should be updated to reflect the practice of electronic claims submission. We suggest the following language be adopted. *"Ambulance services are reimbursed directly by Medicaid and must be billed on CMS 1500 forms, or the electronic equivalent, using the appropriate procedure codes and modifiers."*		Medicaid and must be billed on CMS 1500 forms, **or the electronic equivalent,** using the appropriate procedure codes and modifiers.	suggested language in Section 524.4
15	7/24/15	524.4.1 Billing This section references the	**NC**		Rates will not be increased at this time.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		ambulance fee schedule. Medicaid reimbursements for ambulance services have not increased in nearly 15 years. The last increase in Medicaid rates for ambulance providers occurred on November 1, 2000, when the AMT Code (now BLS-non-emergency) was increased to $90.00 per trip and the mileage for ALS, BLS and AMT was raised to $3.80 per mile. The AMT increase was part of an agreement to maintain budget neutrality when the provider manual was revised in 1999-2000, so providers actually experienced no new revenue from the change. The mileage adjustment was to help offset a significant increase in the cost of fuel at that time. When the last mileage increase for ambulance services was granted in November 2000, the			

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		U.S. average retail diesel fuel price was $1.61 per gallon. The current national average according to the Energy Information Administration is $2.79 per gallon. This represents a 73% increase in fuel cost without any increase in mileage rates from the Medicaid program. The impact of the rise in fuel costs are compounded when you consider ambulances are only reimbursed for mileage accrued while transporting patients. This means squads typically drive 2 miles for every mile billed. Ambulance squads have faced similar rate increases in employee wages. In November 2000, the federal minimum wage was $5.15 per hour. The current West Virginia minimum wage is now $8.00 per hour – a			

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		55 percent increase since the last ambulance rate adjustment. The true increase in wage costs for most squads is actually far higher as they compete with other health care professions and employers such as nurses and hospitals for employees. Ambulance squads have also incurred significant increases in the cost of medical equipment, pharmaceuticals and other supplies over the past 15 years including the cost of mandated upgrades to the equipment carried on every ambulance to meet improvements in medical technology. Additionally, suppliers have increased prices as they pass along the 2.3% medical equipment tax that was included in the Accountable and Affordable Care Act.			

Comments for Chapter 524 Transportation

Effective Date 9/18/15

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		While ambulance providers recognize the budget challenges currently faced by the Medicaid program, squads have struggled through nearly 15 years of stagnant reimbursement rates. They can't continue to wait any longer for a rate review and adjustment. As BMS works to make revisions to it manuals and policies, the West Virginia EMS Coalition would strongly urge Medicaid to review and update its fee schedule in recognition of the increased cost ambulance squads have incurred over the past 15 years in delivering services to Medicaid recipients.			
16	7/24/15	524.5 Non-Covered Services The sixth bullet in this section again makes reference to services that require prior	**NC**		BMS is not changing the requirement that transportation is only reimbursed when the service is covered, which

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		authorization. The ambulance provider community is unaware of prior authorization process or BMS contractors for non-emergency ambulance transportation. If such a process or contractor exists or will be implemented in the immediate future, we would requests additional information that we can share with members to ensure compliance with the requirements of the BMS transportation manual.			includes the requirement that it be prior authorized if applicable.
17	7/24/15	524.5 Non-Covered Services The section further states that services are not covered when provided by ambulance providers for transportation to the emergency room for routine medical care. Reimbursed should be based upon presenting symptoms at time of dispatch and transport while applying a prudent layperson standard. The	**NC**		The regulation, taken as a whole, adequately describes when ambulance transportation is appropriate. See section 524.2.2 and the associated appendix, which outline criteria for reimbursable use of BLS ambulance.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		ambulance squad's reimbursement should not be dictated by the level of care provided at the emergency room if symptoms presented to the ambulance provider indicate a medical emergency exists. We believe this bullet related to routine medical care is inappropriate for our provider type and should be deleted.			
18	7/24/15	524.5 Non---Covered Services The last sentence of this section states, "non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review. The formatting of this section makes it unclear if this applies just to non-ambulance providers or if it applies to ambulance providers as well. Do ambulance squads have the ability to appeal if a service is ruled non-covered by BMS? Squads have expressed to our organization an unfamiliarity	**NC**		No transportation provider, and in fact no Medicaid provider, can appeal a non-covered service. The decision regarding whether or not to cover a service is a policy decision, and as such is not eligible for appeal. In order to clarify that this applies to all transportation providers we are moving the sentence from its current location to the beginning of the section.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		with DHHR Fair Hearing and Desk/Document review processes. Could BMS provide additional information detailing how these hearing and reviews work including any written policies and procedures related to them?			
19	7/25/15	Section 524.1 Provider Participation All participating patient transportation providers must have current coverage of errors and omissions liability and/or auto insurance liability of an amount not less than one million dollars or as required under current West Virginia law or specified by the Broker. Section 524.1.3 Ongoing Compliance All participating transportation providers must maintain and be able to verify current errors and omissions liability and/or auto insurance liability coverage of an amount not less than one million dollars or as required under West Virginia current law.	**C**	**Change to 524.1** All transportation services must be provided by an individual with a valid driver's license. All participating patient transportation providers must have current coverage of errors and omissions liability and/or auto insurance liability. In the case of ambulance transportation providers, the amount	BMS changed the language in Section 524.1 Provider Participation and Section 524.1.3 Ongoing Compliance to clarify error and omissions liability and/or auto insurance liability requirements.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
				of liability coverage cannot be less than one million dollars as required by West Virginia State Code §16-4C-16. The broker's non-ambulance transportation providers are subject to the amount of liability required by current state law or specified by the Broker. **Change to 524.1.3** All participating patient transportation providers must maintain and be able to verify current coverage of errors and omissions liability and/or auto insurance. In the case of ambulance	

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				transportation providers, the amount of liability coverage cannot be less than one million dollars as required by West Virginia State Code §16-4C-16. The broker's non-ambulance transportation providers are subject to the amount of liability required by current state law or specified by the Broker.	