

Non-Emergent Ambulance Transportation for Tufts Medicare Preferred (HMO and PPO)

Effective: January 1, 2025

<p>Prior Authorization Required If <u>REQUIRED</u>, submit supporting clinical documentation pertinent to service request to the FAX numbers below</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>Notification Required IF <u>REQUIRED</u>, concurrent review may apply</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>

Applies to:

Commercial Products

- Harvard Pilgrim Health Care Commercial products; 800-232-0816
- Tufts Health Plan Commercial products; 617-972-9409
CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
- Tufts Health One Care Plan – A dual-eligible product; 857-304-6304

Senior Products

- Harvard Pilgrim Health Care Stride Medicare Advantage; 888-609-0692
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
- Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
- Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

SSBCI (Special Supplemental Benefits for the Chronically Ill) plans do not require prior authorization for Non-Emergent Ambulance Transportation. Please refer to Member documents for additional details.

Overview

Consistent and reliable patient access to care is essential for patient wellness and chronic care management. Nonemergency medical transportation (NEMT) includes transportation services offered to patients who face barriers getting to their medical appointments. Those barriers can include not having a valid driver's license, not having a working vehicle in the household, being unable to travel or wait for services alone, or having a physical, cognitive, mental, or developmental limitation. NEMT services are intended for medical appointments or other forms of non-emergency care. Non-emergency medical transportation differs from emergency transportation in that NEMT is intended:

- For members' whose medical need is NOT immediate. Symptoms are neither severe, life-threatening (e.g., a heart attack), nor due to a serious event (e.g., car accident); AND
- To ensure members are able to attend necessary medical appointments; AND
- To ensure the most appropriate mode of transportation is used for the Member's health condition

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations where available. Medicare Benefit Policy Manual Chapter 10- Ambulance Services is being used to provide details regarding medical necessity for its Medicare Advantage plan members.

The Plan may cover **non-emergency, basic or advanced life support, ground** ambulance when documentation confirms the following:

1. The member's medical condition is such that use of any other method of transportation is contraindicated e.g., bed confinement (member is unable to ambulate with or without assistance or assistive device and member is unable to sit in a chair or wheelchair);

The Plan may cover **non-emergency fixed wing air ambulance** is considered medically necessary when documentation confirms the member is inaccessible by ground ambulance for non-emergent purposes

Please note the following:

- Prior authorization is not required for wheelchair vans, chair cars, or ride share forms of transportation. Please refer to the member handbook for additional details.
- The Plan only covers non-emergency ambulance transportation from origins or to destinations listed in Table 2. Even when medical necessity criteria are otherwise met, if the locations requested do not appear in Table 2, the Plan will not cover the non-emergency ambulance transportation.
- Non-Emergent Ambulance Transport from Hospital to Hospital is covered without prior authorization

Limitations

The Plan considers non-emergency ground or air, ambulance transportation as not covered when:

1. The trip is not medically necessary (e.g., for member/family convenience or preference)
2. An alternate mode of transportation (e.g., taxicab, public transportation, personal car) is available
3. Mode of transportation is not in accordance with applicable local, state, and federal regulatory, certification, and licensing requirements; OR
4. Medical personnel present during transport are not in accordance with applicable local, state, and federal regulatory, certification, and licensing requirements
5. Non-Emergency Ambulance Transportation to the member's physician's office is not a covered destination, however the physician's office may be a covered **stop** on a case by case review.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
A0426	Ambulance service, advanced life support, non-emergency transport level 1 (ALS1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0435	Fixed wing air mileage, per statute mile

Table 2: Covered Modifier Codes:

The following modifier combinations when submitted with a HCPCS code above is covered when criteria is met.

Modifier	Description
JH	Non-hospital-based dialysis facility to hospital
HJ	Hospital to non-hospital-based dialysis facility
HN	Hospital to skilled nursing facility

Modifier	Description
NH	Skilled nursing facility to hospital
HR	Hospital to beneficiary residence
RH	Beneficiary residence to Hospital
RJ	Beneficiary residence to non-hospital-based dialysis facility
JR	Non-hospital-based dialysis facility to Beneficiary residence

References:

- Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual Chapter 10 - Ambulance Services, 2018. [cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf). Accessed October 8, 2022.
- Code of Federal Regulations: Title 42 - Public Health Chapter IV – Centers for Medicare & Medicaid Services Department of Health and Human Services, Subchapter B – Medicare Program Part 410 – Supplementary Medical Insurance Benefits, Subpart B - Medical and Other Health Services: Section 410.40 – Coverage of Ambulance Services.

Approval And Revision History

September 19, 2024: Service reviewed and approved by the Joint Medical Policy and Health Care Services Utilization Management Committee effective January 1, 2025

Subsequent endorsement date(s) and changes made:

- October 17, 2024: Reviewed by the Medical Policy Approval Committee (MPAC) effective, January 1, 2025

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.