CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines: **Non-Emergent Ambulance Transportation for CarePartners of Connecticut**

Effective: January 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers blow.	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 857-304-6463
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 857-304-6463

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

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

Codes

The following codes require prior authorization:

Table 1:

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
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:

1. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual Chapter 10 - Ambulance Services, 2018. cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf. Accessed October 8, 2022.
2. 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: 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.

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.