

Medical Policy

**Ambulance and Transportation Services**

**Policy Number:** OCA 3.191

**Version Number:** 20

**Version Effective Date:** 12/01/21

<b>Product Applicability</b>		<input type="checkbox"/> <b>All Plan<sup>+</sup> Products</b>
<b>WellSense Health Plan</b>		<b>Boston Medical Center HealthNet Plan</b>
<input checked="" type="checkbox"/> NH Medicaid	<input type="checkbox"/> NH Medicare Advantage	<input checked="" type="checkbox"/> MassHealth ACO
		<input checked="" type="checkbox"/> MassHealth MCO
		<input checked="" type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct
		<input checked="" type="checkbox"/> Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

**Policy Summary**

The Plan considers ambulance and transportation services **medically necessary** when Plan medical criteria are met. Prior authorization may or may not be required for Plan MassHealth, Senior Care Options (SCO), Qualified Health Plan (QHP), and WellSense New Hampshire Medicaid product according to the guidelines specified in the Clinical Criteria sections.

One Call Government Solutions, LLC (One Call) manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for WellSense New Hampshire Medicaid members, SCO members, and WellSense Medicare Advantage HMO members. One Call may be contacted directly at 1-844-909-7433 or 1-844-909-RIDE (and hearing impaired members may instead dial 711 to be connected to an operator who will then connect the member to One Call).

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The Plan determines the medical necessity of transportation services according to the following notification guidelines:

1. **BMC HealthNet Plan Members (Except Senior Care Options Members):** Contact the Plan for prior authorization requests for non-emergency sea transport, non-emergent air transport, non-emergent chair car/wheelchair van transport, and/or non-emergent ground ambulance transport, services for Plan **MassHealth** and **Qualified Health Plans** members (including both member and provider requests for service).

For Plan **MassHealth** members, non-emergency transportation by land ambulance, chair car, taxi, and common carriers that generally are pre-arranged to transport a member to and from covered medical care in Massachusetts or within 50 miles or less of the Massachusetts border are covered directly by MassHealth (rather than the Plan) and may require authorization directly from MassHealth; however, the Plan will assist in the coordination of these services. (This MassHealth coverage guideline does NOT apply to SCO members with MassHealth benefits.) For Plan MassHealth members, all other types of covered ambulance and transportation services that require prior authorization are managed by the Plan.

2. **Senior Care Options Members: Contact the Plan** rather than One Call for prior authorization requests for **non-emergent** sea transport, **non-emergent** air transport, non-emergent chair car/wheelchair van transport, **non-emergent** ground ambulance transport, and/or medically necessary general transportation services for Senior Care Options members, including requests from members or providers. One Call will manage the travel arrangements for non-emergency ambulance and transportation services after the Plan has determined the medical necessity of treatment with the prior authorization process. This includes all non-emergent transportation and associated transportation services (even if the corresponding code are not listed in this policy's applicable coding section.) Verify member benefits and eligibility for the type of non-emergency transportation requested (and corresponding services) in addition to obtaining prior authorization for services.
3. **WellSense New Hampshire Medicaid Members: Contact One Call directly** rather than the Plan for requests for non-emergent sea transport, non-emergent air transport, non-emergent chair car/wheelchair van transport, non-emergent ground ambulance transport, and/or medically necessary general transportation services for WellSense New Hampshire Medicaid members, including both member and provider requests for service. This includes all non-emergent transportation and associated transportation services (even if the corresponding code are not listed in this policy's applicable coding section.) Ambulance services are not covered outside the United States and its territories.
4. **WellSense Medicare Advantage HMO Members:** Prior authorization is NOT required for covered non-emergency transportation services provided to WellSense Medicare Advantage members as a supplemental benefit. Review the member's benefit documents posted at

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[www.WellSense.org/Medicare](http://www.WellSense.org/Medicare) for coverage guidelines and maximum number of trips included in the transportation supplemental benefit for WellSense Medicare Advantage members. Benefit exceptions do require Plan prior authorization.

It will be determined during the Plan's prior authorization process if the ambulance transport is considered medically necessary for the requested service. As required by state regulations and/or benefit coverage, different Plan medical criteria are specified for BMC HealthNet Plan products, Senior Care Options product, and WellSense New Hampshire Medicaid product. See the applicable Clinical Criteria section for medical criteria.

### **Clinical Criteria for BMC HealthNet Plan MassHealth and QHP Products**

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Contact the Plan for prior authorization requests for non-emergency ambulance and transportation services for BMC HealthNet Plan members, including both member and provider requests for service. The Plan considers ambulance and transportation services to be medically necessary when the following applicable Plan criteria are met in item A or item B:

#### **A. Prior Authorization is NOT Required:**

The Plan covers ANY of the scenarios in items 1 through 3 WITHOUT prior authorization:

##### **1. Emergency Ground Ambulance Transportation:**

The Plan covers ground ambulance transportation to the nearest acute care medical facility (or within the member's locality for BMC HealthNet Plan MassHealth members) for **emergency** medical care for an emergency behavioral health condition or emergency medical condition and ALL of the criteria in items a through c are met:

- a. The ambulance is equipped with appropriate emergency medical supplies and equipment with appropriate staff; AND
- b. The member's condition is such that any other form of transportation would be medically contraindicated; AND
- c. The member will be transported to the nearest hospital or emergency facility for the treatment of the member's illness or injury; OR

Note: Prior authorization is required when ALL of these criteria for ground ambulance transportation are NOT met. For BMC HealthNet Plan MassHealth members, the Plan will cover emergent transportation to a source of medical care only within the member's locality, unless authorized by the Plan. Locality is defined as the town or city in which a member resides and the surrounding communities within 25 miles of the town or city in which the member resides.

## 2. **Emergency Air Transportation or Sea Ambulance Transportation:**

Air transportation or sea ambulance transportation is covered for **emergency** medical care for an emergency behavioral health condition or emergency medical condition when ANY criteria in item a or item b is met:

- a. Ground ambulance cannot be used to access the member for an **emergency** medical condition (with ALL criteria specified above in item A1 are met); OR
- b. Air ambulance transport or sea ambulance transport is medically necessary to manage the member's emergency medical condition when ALL criteria in items (1) through (4) are met:
  - (1) The ambulance is equipped with appropriate emergency medical supplies and equipment and appropriate staff; AND
  - (2) The member will be transported to the nearest hospital or emergency facility for the treatment of the member's illness or injury; AND
  - (3) The member's clinical condition requires immediate transport to the nearest appropriate emergency hospital or facility and this transportation cannot be safely provided on a timely basis via an Advanced Life Support (ALS) ground ambulance because the location is inaccessible by ground vehicle/ambulance and/or the distance (or other obstacles) are involved in getting the member to the nearest emergency hospital or facility for treatment using ground ambulance transportation; AND
  - (4) The member's clinical condition is such that transportation by any other means poses a threat to the member's health (e.g., member is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the member to the nearest facility capable of treating the member); OR

Note: Prior authorization is required when ALL of these criteria are NOT met. "Air ambulance" means a fixed-wing or rotary-wing aircraft that is certified by the Federal Aviation Administration as an air ambulance and which is designed and equipped for the provision of medically necessary supplies and services.

## 3. **Ground Ambulance Transportation Between Inpatient Facilities:**

Ground ambulance transport is covered when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan; OR

Note: For MassHealth Plan members, non-emergency transportation by land ambulance, chair car, taxi, and common carriers that generally are pre-arranged to transport a member to and

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from covered medical care in Massachusetts or within 50 miles or less of the Massachusetts border are covered directly by MassHealth (rather than the Plan) and may require authorization directly from MassHealth; however, the Plan will assist in the coordination of these services. All other covered ambulance and transportation services that require prior authorization are managed by the Plan. (This MassHealth coverage guideline does NOT apply to SCO members with MassHealth benefits.)

**B. Prior Authorization is REQUIRED:**

All transportation scenarios not specified in item A above require prior authorization by the Plan, including but not limited to ANY of the following in item 1 or item 2:

**1. Non-Emergent Sea Transportation or Non-Emergent Air Transportation:**

**a. Criteria for All Boston Medical Center HealthNet Plan Products:**

Non-emergent sea transportation or non-emergent air transportation to and/or from medically necessary care is covered when BOTH criteria in items (1) and (2) are met:

- (1) Transport is to a **contracted or Plan authorized** medically appropriate acute care medical facility predetermined and authorized by the Plan; AND

Note: Public airline charges may be authorized for the member in lieu of air ambulance services only when the Plan determines that the member could be safely and less expensively transported on a public airline accompanied by necessary medical attendants.

- (2) ANY criteria is met in items (a) through (c):

- (a) The member's medical condition requires medical attention during transport and ANY criteria is met in item i or item ii:

- i. The use of ground transportation is contraindicated or inappropriate to ensure the member's safe transfer; OR
- ii. A ground ambulance cannot be used to access the member (i.e., the point of pick up is not accessible by a land vehicle); OR

- (b) An ill or injured member who received urgent or emergent care outside the service area is determined to be medically stable for transport back to the Plan service area but requires medical attention during transport to ensure a safe return; OR

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- (c) The time needed to provide transport for a patient by land, or the instability of transportation by land, poses a threat to the member's condition or survival; OR

**2. Other Types of Plan Authorized Non-Emergency Transportation:**

ANY criteria is met in item a or item b:

**a. Non-Emergent Chair Car or Non-Emergent Wheelchair Van Transportation: ±**

ALL criteria are met in items (1) through (4):

- (1) Member requires transportation to and/or from a covered medical service (e.g., clinic, therapy center, physician's office, or dialysis center), dental service, and/or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic or therapeutic service); AND
- (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND
- (3) Member is unable to safely transfer from a wheelchair to a vehicle with or without assistance; AND
- (4) Member is unable to ambulate with or without assistance or a device; OR

**b. Non-Emergent Ground Ambulance Transportation:**

ALL criteria are met in items (1) through (3):

- (1) Member requires transportation to and/or from a covered medical service (e.g., clinic, therapy center, physician's office, dialysis center, or emergency department), dental service, and/or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic or therapeutic service); AND
- (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND
- (3) Member meets ANY criteria in items (a) through (h):
  - (a) The member is bed confined (defined as unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair); OR

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- (b) The member cannot safely sit upright while seated in a wheelchair; OR
- (c) The member can tolerate a wheelchair but is medically unstable; OR
- (d) The member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain; OR
- (e) The member requires isolation due to communicable disease or hazardous material exposure; OR
- (f) The member has a major orthopedic device that specifically precludes the member from sitting in a wheelchair van or chair car; examples may include backboard, halo-traction, Spica cast, use of pins and traction; OR
- (g) The member requires special positioning to prevent further injury (i.e., decubiti or other wound, contracture, post-op hip fracture, severe pain, or the member's size and/or medical condition is such that more than one person is needed for transfer); OR
- (h) The member is at risk of harming him/herself or others.

Note: For Plan MassHealth members, non-emergency transportation by land ambulance, chair car, taxi, and common carriers that generally are pre-arranged to transport a member to and from covered medical care in Massachusetts or within 50 miles or less of the Massachusetts border are covered directly by MassHealth (rather than the Plan) and may require authorization directly from MassHealth; however, the Plan will assist in the coordination of these services. (This MassHealth coverage guideline does NOT apply to SCO members with MassHealth benefits.) For Plan MassHealth members, all other types of covered ambulance and transportation services that require prior authorization are managed by the Plan.

## **Clinical Criteria for Senior Care Options (SCO) Product**

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Contact the Plan for prior authorization requests for non-emergency ambulance and transportation services for Senior Care Options members (including both member and provider requests for service). The Plan will authorize and oversee medically necessary covered non-emergency transport for the Senior Care Options member. After Plan approval, One Call Government Solutions, LLC (One Call) may serve as the Plan's designee to coordinate the travel arrangements for covered non-emergent sea transport, non-emergent air transport, non-emergent chair car/wheelchair van transport, non-emergent ground ambulance transport, and/or general transportation services when medically necessary and a component of the member's individualized care plan.

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The Plan determines the medical necessity of transportation services based on the Plan medical criteria specified in this section. The Plan considers ambulance and transportation services to be medically necessary when the following applicable criteria are met in item A or item B:

**A. Prior Authorization is NOT Required:**

The Plan covers ANY of the scenarios in items 1 through 3 WITHOUT prior authorization:

**1. Emergency Ground Ambulance Transportation:**

The Plan covers ground ambulance transportation to the nearest acute care medical facility (or within the member's locality for BMC HealthNet Plan MassHealth members) for **emergency** medical care for an emergency behavioral health condition or emergency medical condition and ALL criteria in items a through c are met:

- a. The ambulance is equipped with appropriate emergency medical supplies and equipment with appropriate staff; AND
- b. Member's condition is such that any other form of transportation would be medically contraindicated; AND
- c. Member will be transported to the nearest hospital or emergency facility for the treatment of the member's illness or injury; OR

Note: Prior authorization is required when ALL of these criteria for ground ambulance transportation are NOT met.

**2. Emergency Air Transportation or Sea Ambulance Transportation: ‡**

Air transportation or sea ambulance transportation is covered for **emergency** medical care for an emergency behavioral health condition or emergency medical condition (as defined in the Definitions section of this policy) when ANY criteria is met in item a or item b:

- a. Ground ambulance cannot be used to access the member for an **emergency** medical condition (with ALL criteria specified above in item A1 are met); OR
- b. Air ambulance transport or sea ambulance transport is medically necessary to manage the member's emergency medical condition when ALL criteria in items (1) through (4) are met:
  - (1) The ambulance is equipped with appropriate emergency medical supplies and equipment and appropriate staff; AND

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- (2) The member will be transported to the nearest hospital or emergency facility for the treatment of the member's illness or injury; AND
- (3) The member's clinical condition requires immediate transport to the nearest appropriate emergency hospital or facility and this transportation cannot be safely provided on a timely basis via an Advanced Life Support (ALS) ground ambulance because the location is inaccessible by ground vehicle/ambulance and/or the distance (or other obstacles) are involved in getting the member to the nearest emergency hospital or facility for treatment using ground ambulance transportation; AND
- (4) The member's clinical condition is such that transportation by any other means poses a threat to the member's health (e.g., member is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the member to the nearest facility capable of treating the member); OR

Note: Prior authorization is required when ALL of these criteria are NOT met. Air ambulance" means a fixed-wing or rotary-wing aircraft that is certified by the Federal Aviation Administration as an air ambulance and which is designed and equipped for the provision of medically necessary supplies and services.

### 3. **Ground Ambulance Transportation Between Inpatient Facilities:**

Ground ambulance transport is covered when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan; OR

## B. **Prior Authorization is REQUIRED:**

ANY criteria must be met in item 1 or item 2:

### 1. **Non-Emergent Sea Transportation or Non-Emergent Air Transportation:**

BOTH criteria must be met in item a and item b:

- a. The non-emergent sea transportation or non-emergent air transportation is prescribed by the member's primary care provider or treating provider; AND
- b. Ground transportation is contraindicated, inappropriate to ensure the member's safe transfer, or cannot be used to access the member; OR

### 2. **Other Types of Plan Authorized Non-Emergency Transportation:**

ANY criteria must be met in items a through c:

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**a. Non-Emergent Chair Car or Non-Emergent Wheelchair Van Transportation:**

ALL criteria must be met in items (1) through (4):

- (1) Member requires non-emergent chair care or non-emergent wheelchair van transportation to a covered medical service, dental service, behavioral health service, and/or transport to a pharmacy when it is a covered destination according to the CMS Medicare Benefit Policy Manual in effect at the time of the prior authorization request, or the transportation service is authorized by the Plan for care management and integration of medically necessary services for the member's individualized care plan; AND
- (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND
- (3) Member is unable to safely transfer from a wheelchair to a vehicle with or without assistance; AND
- (4) Member is unable to ambulate with or without assistance or a device; OR

**b. Non-Emergent Ground Ambulance Transportation:**

BOTH criteria must be met in items (1) and (2):

- (1) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND
- (2) Member meets ANY criteria in items (a) through (i):
  - (a) Member requires non-emergent ground transportation to a covered medical service, dental service, behavioral health service, and/or transport to a pharmacy when it is a covered destination according to the CMS Medicare Benefit Policy Manual in effect at the time of the prior authorization request, or the transportation service is authorized by the Plan for care management and integration of medically necessary services for the member's individualized care plan; OR
  - (b) Member is bed confined (defined as unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair); OR
  - (c) Member cannot safely sit upright while seated in a wheelchair; OR

- (d) Member can tolerate a wheelchair but is medically unstable; OR
- (e) Member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain; OR
- (f) Member requires isolation due to communicable disease or hazardous material exposure; OR
- (g) Member has a major orthopedic device that specifically precludes the member from sitting in a wheelchair van or chair car; examples may include backboard, halo-traction, Spica cast, use of pins and traction; OR
- (h) Member requires special positioning to prevent further injury (i.e., decubiti or other wound, contracture, post-op hip fracture, severe pain, or the member's size and/or medical condition is such that more than one person is needed for transfer); OR
- (i) Member is at risk of harming him/herself or others; OR

**c. General Transportation:**

The member requires general transportation services (excluding coverage for private transportation services that may include but are not limited to a taxi service, private car service, and/or transportation provided by a member, family member, friend, volunteer, and/or significant other) to a covered medical service, dental service, behavioral health service, and/or transport to a pharmacy when it is a covered destination according to the CMS Medicare Benefit Policy Manual in effect at the time of the prior authorization request, or the transportation service is authorized by the Plan for care management and integration of medically necessary services for the member's individualized care plan (unless specified otherwise in the Limitations and Exclusions section). General transportation services must be authorized by the Plan for the mode of transportation and indication for transport, arrangements are coordinated by the Plan's Care Management staff (or One Call as the Plan's designee), and the transportation service is covered for the member.

## **Clinical Criteria for WellSense New Hampshire Medicaid Product**

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Contact One Call Government Solutions, LLC (One Call) directly at 1-844-909-7433 or 1-844-909-RIDE (and hearing impaired members may instead dial 711 to be connected to an operator who will then connect the member to One Call) rather than the Plan for requests for covered non-emergent sea transport, non-emergent air transport, non-emergent chair car/wheelchair van transport, non-emergent ground ambulance transport, and/or medically necessary general transportation services for WellSense New Hampshire Medicaid members (with the United States and its territories, including

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both member and provider requests for service. One Call will coordinate medically necessary covered general transportation services and all non-emergency transport on behalf of Plan members (and will direct requests to the Plan's Care Management staff for medically necessary non-emergent transportation requests over 100 miles one way for a WellSense New Hampshire Medicaid member).

The Plan considers ambulance and transportation services to be medically necessary when the following applicable Plan criteria are met in item A or item B:

**A. Prior Authorization is NOT Required:**

Emergency ambulance services will transport a member to the nearest facility that can provide the member with appropriate care. The Plan covers ANY of the scenarios in items 1 through 3 without prior authorization:

**1. Emergency Ground Ambulance Transportation: †**

The Plan covers ground ambulance transportation to the nearest acute care medical facility for **emergency** medical care for an emergency behavioral health condition or emergency medical condition and ALL criteria in items a through c are met:

- a. The ambulance is equipped with appropriate emergency medical supplies and equipment with appropriate staff; AND
- b. Member's condition is such that any other form of transportation would be medically contraindicated; AND
- c. Member will be transported to the nearest hospital or emergency facility for the treatment of the member's illness or injury; OR

Note: Prior authorization is required when ALL of these criteria for ground ambulance transportation are NOT met.

**2. Emergency Air Transportation or Sea Ambulance Transportation: ‡**

Air transportation or sea ambulance transportation is covered for **emergency** medical care for an emergency behavioral health condition or emergency medical condition when ANY criteria is met in item a or item b:

- a. Ground ambulance cannot be used to access the member for an **emergency** medical condition (with ALL criteria specified above in item A1 are met); OR
- b. Air ambulance transport or sea ambulance transport is medically necessary to manage the member's emergency medical condition when ALL criteria in items (1) through (4) are met:

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- (1) The ambulance is equipped with appropriate emergency medical supplies and equipment and appropriate staff; AND
- (2) Member will be transported to the nearest hospital or emergency facility for the treatment of the member's illness or injury; AND
- (3) Member's clinical condition requires immediate transport to the nearest appropriate emergency hospital or facility and this transportation cannot be safely provided on a timely basis via an Advanced Life Support (ALS) ground ambulance because the location is inaccessible by ground vehicle/ambulance and/or the distance (or other obstacles) are involved in getting the member to the nearest emergency hospital or facility for treatment using ground ambulance transportation; AND
- (4) Member's clinical condition is such that transportation by any other means poses a threat to the member's health (e.g., member is at imminent risk of losing life or limb if the fastest means of transport is not utilized to move the member to the nearest facility capable of treating the member); OR

Note: Prior authorization is required when ALL of these criteria are NOT met. Air ambulance" means a fixed-wing or rotary-wing aircraft that is certified by the Federal Aviation Administration as an air ambulance and which is designed and equipped for the provision of medically necessary supplies and services.

### 3. **Ground Ambulance Transportation Between Inpatient Facilities:**

Ground ambulance transport is covered when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan; OR

### B. **Prior Authorization is REQUIRED:**

All other transportation scenarios not specified above in item A require prior authorization by the Plan, including but not limited to ANY of the following listed in item 1 or item 2:

#### 1. **Non-Emergent Sea Transportation or Non-Emergent Air Transportation:**

Non-emergent sea transportation or non-emergent air transportation to and/or from medically necessary care is covered when BOTH criteria are met in item a and item b:

- a. Transport is to a **contracted or Plan authorized** medically appropriate acute care medical facility predetermined and authorized by the Plan; AND
- b. ANY criteria is met in items (1) through (4):

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- (1) Member's medical condition requires medical attention during transport and ANY criteria is met in item (a) or item (b):
  - (a) The use of ground transportation is contraindicated or inappropriate to ensure the member's safe transfer; OR
  - (b) A ground ambulance cannot be used to access the member (i.e., the point of pick up is not accessible by a land vehicle); OR
- (2) An ill or injured member who received urgent or emergent care outside the service area is determined to be medically stable for transport back to the Plan service area but requires medical attention during transport to ensure a safe return; OR
- (3) The time needed to provide transport for a patient by land, or the instability of transportation by land, poses a threat to the member's condition or survival; OR
- (4) The non-emergent sea transportation or non-emergent air transportation is prescribed by the member's primary care provider or treating provider and ground transportation is contraindicated, inappropriate to ensure the member's safe transfer, or cannot be used to access the member; OR

Note: Public airline charges may be authorized for the member in lieu of air ambulance services only when the Plan determines that the member could be safely and less expensively transported on a public airline accompanied by necessary medical attendants. Coverage for ambulance services complies with applicable New Hampshire regulations (including He-W 572).

### **3. Other Types of Plan Authorized Non-Emergent Transportation:**

ANY criteria must be met in items a through c:

#### **a. Non-Emergent Chair Car or Non-Emergent Wheelchair Van Transportation:**

ALL criteria must be met in items (1) through (4):

- (1) The member requires transportation to and/or from a covered medical service (e.g., clinic, therapy center, physician's office, or dialysis center), dental service, and/or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic and/or therapeutic service, as specified otherwise in the Limitations section of this Plan policy), with coverage

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according to the member's benefit document and applicable New Hampshire regulations (including He-W 572); AND

- (2) The member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND
- (3) The member is unable to safely transfer from a wheelchair to a vehicle with or without assistance; AND
- (4) The member is unable to ambulate with or without assistance or a device; OR

**b. Non-Emergent Ground Ambulance Transportation:**

ALL criteria must be met in items (1) through (3):

- (1) Member requires transportation to and/or from a covered medical service (e.g., clinic, therapy center, physician's office, or dialysis center), dental service, and/or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic and/or therapeutic service, as specified otherwise in the Limitations section of this Plan policy), with coverage according to the member's benefit document and applicable New Hampshire regulations (including He-W 572 and He-W 574); AND
- (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND
- (3) Member meets ANY criteria in items (a) through (k):
  - (a) The non-emergent ground ambulance transportation is prescribed by the member's primary care provider or treating provider; OR
  - (b) Member is bed confined (defined as unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair); OR
  - (c) Member cannot safely sit upright while seated in a wheelchair and must be transported in a **supine position**; OR
  - (d) Member can tolerate a wheelchair but is medically unstable; OR

- (e) Member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain; OR
- (f) Member requires isolation due to communicable disease or hazardous material exposure; OR
- (g) Member has a major orthopedic device that specifically precludes the member from sitting in a wheelchair van or chair car; examples may include backboard, halo-traction, Spica cast, use of pins and traction; OR
- (h) Member requires special positioning to prevent further injury (i.e., decubiti or other wound, contracture, post-op hip fracture, severe pain, or the member's size and/or medical condition is such that more than one person is needed for transfer); OR
- (i) Member is at risk of harming him/herself or others and requires **restraints** during transport; OR
- (j) Member requires **skilled/trained monitoring with life support equipment** during transport, which may include but is not limited to a member with ANY conditions in items I through vi:
  - i. The member is comatose; OR
  - ii. The member requires airway monitoring; OR
  - iii. The member requires cardiac monitoring; OR
  - iv. The member is dependent on a ventilator; OR
  - v. The member requires suctioning; OR
  - vi. The member requires the supply and/or regulation of oxygen; OR
- (k) Member requires **skilled/trained monitoring** during transport for ANY conditions in items i through vi:
  - i. The member is comatose; OR
  - ii. The member requires airway monitoring; OR



- iii. The member requires cardiac monitoring; OR
- iv. The member is dependent on a ventilator; OR
- v. The member requires suctioning; OR
- vi. The member requires the supply and/or regulation of oxygen; OR

**c. General Transportation:**

General transportation services are covered and consider medically necessary when the WellSense New Hampshire Medicaid member requires general transportation services to a covered medical service, dental service, behavioral health service, and/or transport to a pharmacy (if the pharmacy does not provide free delivery services to the member's home) ONLY when the transportation is authorized by One Call (as the Plan's designee) in ADVANCE. Requests for transportation services must be submitted to One Call at least 48 hours before the member's non-urgent appointment time. One Call will accept an urgent request for transportation services with less than 48-hour notification when the treating provider's office has validated that that the member requires an urgent appointment.

One Call must prospectively authorize the mode of transportation and indication for transport, and arrangements must be coordinated by One Call. General transportation services are covered for a WellSense New Hampshire Medicaid member for healthcare services when the member is not able to obtain free transportation (or not eligible for transportation from another agency), as specified in the member's applicable benefit document available at [www.wellsense.org](http://www.wellsense.org) and according to applicable New Hampshire regulations (including He-W 572 and He-W 574). The member is responsible for submitting prior authorization requests in advance to One Call for general transportation services, and the member must comply with all reimbursement guidelines. Covered general transportation services may include public transportation (including bus and/or train) and transportation provided by a One Call provider authorized to transport the member (with mileage reimbursement for the driver according to One Call guidelines). See the WellSense New Hampshire Medicaid Member Handbook rather than this policy for Plan rules for transportation coordination and reimbursement for the Friends and Family Mileage Reimbursement Program and Request a Ride Program.

## **Limitations and Exclusions**

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1. Transportation services listed in items a through g are NOT covered:
  - a. Transportation to and/or from medical appointments, dental appointments, behavioral health appointments, and/or transport to a pharmacy EXCEPT when the specific

Ambulance and Transportation Services

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transportation service is covered and authorized by the Plan or One Call Government Solutions, LLC (One Call) as the Plan's designee.

- b. Private transportation services (such as taxi service, private car service, and/or transportation provided by a member, family member, friend, volunteer, and/or significant other) UNLESS authorized by the Plan or One Call as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
  - c. Public transportation UNLESS authorized by the Plan or One Call as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
  - d. Ambulance transport, non-emergent chair car or non-emergent wheelchair van transportation, or covered general transportation solely for the convenience or preference of a member or the member's family member (unless authorized by the Plan as a medically necessary service and a component of the member's individualized treatment plan).
  - e. Ambulance transport, non-emergent chair car or non-emergent wheelchair van transportation when an alternative method of transportation is available and can be utilized without endangering the member's health status unless authorized by the Plan or One Call as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
  - f. Transport for the purpose of seeking a non-covered service unless authorized by the Plan or One Call as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
  - g. Transport for any purpose other than to receive covered healthcare services from a network provider.
2. The Plan does NOT reimburse additionally for transportation to and/or from the originating inpatient facility to another facility when the originating facility does NOT have the medically necessary diagnostic and/or therapeutic service required for the member's plan of care. The originating inpatient facility is responsible for coverage of the transportation of the member to and from another qualified facility for the medically necessary diagnostic and/or therapeutic service(s), and the originating inpatient facility would be compensated by the Plan at the established inpatient reimbursement rate.

## Variations

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The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles

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(LCAs), and documentation included in Medicare manuals. At the time of the Plan’s most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

**Applicable Coding**

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitation and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Member benefit documents are available at the following websites; [www.bmchp.org](http://www.bmchp.org) for BMC HealthNet Plan members, [www.SeniorGetMore.org](http://www.SeniorGetMore.org) for Senior Care Options members, and [www.wellsense.org](http://www.wellsense.org) for WellSense New Hampshire Medicaid members. The following list of applicable codes applies to BMC HealthNet Plan products (including Senior Care Options) and the WellSense New Hampshire Medicaid products.

HCPCS Codes	Description: The following ambulance codes REQUIRE prior authorization.
A0021	Ambulance service, outside state per mile, transport (Medicaid only)  Plan note: Code payable for Plan MassHealth members. Code is NOT payable for Qualified Health Plan (QHP) and Senior Care Options (SCO) members.
A0100	Nonemergency transportation; taxi  Plan note: Code is NOT payable for QHP members.

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A0110	<p>Nonemergency transportation and bus, intra- or interstate carrier</p> <p>Plan note: Code is NOT payable for QHP members.</p>
A0120	<p>Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems</p> <p>Plan note: Code is NOT payable for QHP members.</p>
A0130	<p>Nonemergency transportation: wheelchair van</p> <p>Plan note: Code is NOT payable for QHP members.</p>
A0170	<p>Transportation ancillary: parking fees, tolls, other</p> <p>Plan note: Payable by the Plan for MassHealth and SCO members if related to emergency ambulance services and is dependent on the primary transportation code. Code is NOT payable for QHP and WellSense New Hampshire Medicaid members.</p>
A0426	<p>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)</p> <p>Plan note: Code is payable for QHP.</p>
A0428	<p>Ambulance service, basic life support, non-emergency transport (BLS)</p> <p>Plan note: Code is payable for QHP members. Ground ambulance transport is covered and does NOT require prior authorization when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan.</p>
A0433	<p>Advanced life support, level 2 (ALS 2)</p> <p>Plan note: Code is payable for QHP members.</p>
A0434	<p>Specialty care transport (SCT)</p> <p>Plan note: This code is only billable if associated with an emergency transport, or if approved for use as an intra- or interstate transport (interfacility transportation). Code is payable for QHP members.</p>
A0998	<p>Ambulance response and treatment, no transport</p> <p>Plan note: Code is payable for QHP and WellSense New Hampshire Medicaid members. Code is NOT payable for Senior Care Options members.</p>
A0999	<p>Unlisted ambulance service</p> <p>Plan note: Code is payable for QHP members.</p>

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S0215	Non-emergency transportation; mileage, per mile  Plan note: Use this code with wheelchair van transportation to report miles. Code is payable for QHP members. Code is NOT payable for members with MassHealth Family Assistance coverage.
T2001	Nonemergency transportation; patient attendant/escort  Plan note: Code is NOT payable for members with MassHealth Family Assistance coverage. Code is NOT payable for QHP members.
T2005	Non-emergency transportation; stretcher van  Plan note: Code payable for QHP members.
T2049	Non-emergency transportation; stretcher van, mileage; per mile  Plan note: Code payable for QHP members.

## References

American College of Emergency Physicians. EMTALA Main Points.

Centers for Medicare & Medicaid Services (CMS). Ambulances Services Center.

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Publication Number 100-02. Transmittal 130. Change Request 7058. Definition of Ambulance Services. 2010 Jul 29.

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Publication Number 100-02. Chapter 10 – Ambulance Services.

Centers for Medicare & Medicaid Services (CMS). Transmittals.

Centers for Medicare & Medicaid Services (CMS). Welcome to the Medicare Coverage Database.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

New Hampshire Department of Health and Human Services. Billing Manuals.

New Hampshire Department of Health and Human Services. Provider Notices.

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## Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A  Internal Approval: 06/29/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 07/27/11: Quality Improvement Committee (QIC)	01/01/12 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC and QIC

Original Policy Effective Date:

\* Effective Date for the BMC HealthNet Plan Commercial and MassHealth Product: 01/01/12.

\* Effective Date for the WellSense New Hampshire Medicaid Product: 07/01/14.

\* Effective Date for the Senior Care Options Product: 01/01/16.

Transportation Vendor:

- As of 06/01/20, One Call Government Solutions, LLC (One Call) manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for WellSense New Hampshire Medicaid members and Senior Care Options members.
- Prior to 06/01/20, Coordinated Transportation Solutions, Inc. (CTS) managed the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for WellSense New Hampshire Medicaid and Senior Care Options members.

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
07/01/12	Review. Updated reference, revised language in Applicable Code section, included list of applicable codes, added detail on the when to reference the Plan's <i>Reimbursement Guidelines: Transportation</i> policy. Included clarification on limitations on the use of ambulance transport (i.e., limitation when ambulance transport is solely for convenience, when another alternative is safe and available, and/or use with non-covered services).	Version 2	06/20/12: MPCTAC 07/18/12: MPCTAC 08/22/12: QIC
11/01/12	Added Commonwealth Care to list of applicable products (to comply with EOC), removed "Guidelines" from title, updated Summary and	Version 3	11/21/12: MPCTAC 12/20/12: QIC

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## Policy Revisions History

	References sections, reformatted Medical Policy Statement section, added references to sea ambulance (as appropriate).		
03/01/13	Review, deleted redundant text in the Summary section, revised Description of Item or Service section, moved medical criteria from the Summary section to the Medical Policy Statement section (formerly named Clinical Guideline Statement section), updated applicable code list and references, and changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”	Version 4	03/20/13: MPCTAC 04/18/13: QIC
03/01/14	Review for effective date 07/01/14. Added WellSense New Hampshire Medicaid as an applicable product for this policy and included criteria for WellSense New Hampshire Medicaid product. Updated references, applicable code list (adding HCPCS codes S9960 and S9961), and revised language in the Applicable Coding section. Revised Summary section and added note to policy header. Added reference to Coordinated Transportation Solutions, Inc. (CTS), the Plan’s external partner who manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for WellSense New Hampshire Medicaid members. Reformatted and revised criteria for BMC HealthNet Plan products, allowing the approval of transport to a Plan authorized acute care medical facility (as well as a contracted facility).	07/01/14 Version 5	03/19/14: MPCTAC 04/16/14: QIC
06/30/14	Off cycle review for effective date 10/01/14. Removed the following codes from the applicable code list: A0425, A0430, A0431, A0434, A0435, and A0436 (since these codes may be used with emergency transport and Plan prior authorization will not be required).	10/01/14 Version 6	06/30/14: MPCTAC (electronic vote) 07/09/14: QIC
10/31/14	Off cycle review for effective date 12/01/14. Added MassHealth as an applicable product. Updated Summary, Medical Policy Statement, and Limitations sections without changing criteria.	12/01/14 Version 7	10/31/14: MPCTAC (electronic vote) 11/12/14: QIC
03/01/15	Review for effective date 05/01/15. Updated references. Revised the Limitations section to	05/01/15 Version 8	03/18/15: MPCTAC 04/08/15: QIC

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## Policy Revisions History

	reference the member's applicable benefit document without changing the service limitations. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.		
11/01/15	Review for effective date 01/01/16. Updated product applicability template and note. Administrative changes made to the Summary, Limitations, and BMC HealthNet Plan Medical Policy Statement sections to reference the Senior Care Options (SCO) product and interface with Coordinated Transportation Solutions, Inc. (CTS) to manage the travel arrangements for covered non-emergent transport for SCO members. Revised language in the Applicable Coding section.	01/01/16 Version 9	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
05/01/16	Review for effective date 09/01/16. Updated Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Summary, Description of Item or Service, Applicable Coding, and Definitions sections. Criteria changes made in the Medical Policy Statement and Limitations sections. Updated applicable code list.	09/01/16 Version 10	05/31/16: MPCTAC (electronic vote) 06/08/16: QIC
04/01/17	Review for effective date 07/08/17. Updated Summary section. Administrative changes made to the Medical Policy Statement section. Revised the code list, revised Plan notes for applicable codes, and administrative changes made to the Applicable Coding section.	07/08/17 Version 11	04/28/17: MPCTAC
02/01/18	Review for effective date 05/01/18. Administrative changes made to the Policy Summary and Other Applicable Policies sections. Updated criteria in the Medical Policy Statement and Limitations sections. Revised applicable code list.	05/01/18 Version 12	02/21/18: MPCTAC
04/01/18	Review for effective date 05/01/18. Updated Plan notes (administrative changes only) in the Applicable Coding section.	05/01/18 Version 13	04/18/18: MPCTAC
09/01/18	Review for effective date 12/01/18. Revised criteria in the Medical Policy Statement for BMC HealthNet Plan Product, Senior Care Options	12/01/18 Version 14	09/19/18: MPCTAC

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## Policy Revisions History

	Product, and WellSense New Hampshire Medicaid Product sections. Updated the Definitions and the Other Applicable Policies sections.		
03/01/19	Review for effective date 04/01/19. Administrative changes made to the Medical Policy Statement for WellSense New Hampshire Medicaid Product section and the Limitations section. Updated the Plan notes in the Applicable Coding section and revised the Other Applicable Policies section and the Applicable Laws and Regulations section.	04/01/19 Version 15	03/20/19: MPCTAC
11/01/19	Review for effective date 01/01/20. Plan note effective 01/01/20 added to the Applicable Coding section. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	01/01/20 Version 16	11/20/19: MPCTAC
04/01/20	Review for effective date 06/01/20. The Plan has partnered with the non-emergency medical transportation vendor, One Call Government Solutions, LLC (One Call). One Call replaces Coordinated Transportation Solutions, Inc. (CTS) effective 06/01/20 as the manager of travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for members enrolled in the Plan's WellSense New Hampshire Medicaid product or the Senior Care Options product. Administrative changes made to the Policy Summary, Medical Policy Statement for Senior Care Options Products, Medical Policy Statement for WellSense New Hampshire Medicaid Product, Limitations, and Applicable Coding sections.	06/01/20 Version 17	04/15/20: MPCTAC
01/01/21	Review for effective date 04/01/21. Plan notes and coding revised in the Applicable Coding section. Administrative change made to the Other Applicable Policies section.	04/01/21 Version 18	01/19/21: MPCTAC (electronic vote)
02/01/21	Review for effective date 05/01/21. Revised the coding in the Applicable Coding section.	05/01/21 Version 19	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria	12/01/21 Version 20	11/30/21: MPCTAC (electronic vote)

Ambulance and Transportation Services

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## Policy Revisions History

	section, and the Limitations section renamed the Limitations and Exclusions section. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.		
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## Next Review Date

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03/01/22

## Authorizing Entity

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MPCTAC

### Disclaimer Information: +

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.