



Medical Policy

Non-Emergency Transportation Services

Policy Number: OCA 3.191

Version Number: 23

Version Effective Date: 11/01/22

Impacted Products

- All Products**
- NH Medicaid
- NH Medicare Advantage
- MA MassHealth ACO
- MA MassHealth MCO
- MA Qualified Health Plans/Employer Choice Direct
- MA Senior Care Options

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

Policy Summary

The Plan considers non-emergency transportation services medically necessary when Plan criteria are met according to applicable state regulations and benefit coverage. Prior authorization is required. The Plan does NOT require prior authorization for emergency ambulance transportation (including ground, air, and/or sea emergency transport) and/or ground ambulance transport when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan.

Coordinated Transportation Solutions, Inc. (CTS) manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for NH Medicaid members, SCO members, and NH Medicare Advantage HMO members. CTS may be contacted directly at 1-844-909-RIDE for NH Medicaid members and 1-844-458-6226 for NH Medicare Advantage members. When requesting transportation services for a MA Senior Care Options member, call 1-855-833-8125. Hearing impaired members may dial 711 to be connected to an operator who will then connect the member to CTS. Review the following notification guidelines:

1. MA MassHealth Members:
 - a. Non-Emergency Transportation Services Managed Directly by MassHealth: Non-emergency transport by land transport, 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; this includes ground ambulance transport when a member is transported between two (2) inpatient facilities. The Plan will assist in the coordination of these services. (This MassHealth coverage guideline does NOT apply to SCO members with MassHealth benefits.)

- b. Non-Emergency Transportation Services Managed by the Plan: All other types of covered non-emergency transportation services that require prior authorization are managed by the Plan (i.e., transportation greater than 50 miles outside of the Massachusetts border). Verify member benefits and eligibility for the type of non-emergency transportation requested (and corresponding services) in addition to obtaining prior authorization for services. When a code is NOT payable by the Plan for a MassHealth member, contact MassHealth rather than the Plan for coverage guidelines.
2. MA Qualified Health Plans (QHP) Members: Non-emergency transportation services are NOT routinely covered for QHP members. Benefit exceptions do require Plan prior authorization and may include requests for non-emergency sea and/or non-emergency air transportation according to standard medical necessity criteria used for all Plan products. The Plan does cover transportation services when a QHP member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan.
3. MA Senior Care Options (SCO) Members: CTS will manage the travel arrangements for non-emergency transportation services for SCO members.
4. NH Medicaid Members: Contact CTS 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 transport, and/or medically necessary general transportation services for the Plan's NH 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). Transportation services are not covered outside the United States and its territories.
5. NH Medicare Advantage HMO Members: Prior authorization is NOT required for covered non-emergency transportation services provided to NH Medicare Advantage members as a supplemental benefit. Review the member's benefit documents for coverage guidelines and maximum number of trips included in the transportation supplemental benefit. Benefit exceptions do require Plan prior authorization.

Clinical Criteria for MA MassHealth Product

Contact the Plan for requests for non-emergency transportation services. Applicable medical necessity criteria must be met in EITHER 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. Transport is to a contracted or Plan authorized medically appropriate acute care medical facility predetermined and authorized by the Plan; AND

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

- b. ANY criteria is met in items (1) through (3):

- (1) Member's medical condition requires medical attention during transport and EITHER:

(a) The use of ground transportation is contraindicated; OR

(b) Ground transportation is inappropriate to ensure the member's safe transfer; 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

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

Criteria are met in either 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, dental, 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 Transportation:

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

(1) Member requires transportation to and/or from a covered medical, dental, 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 transport by any other means and this method of transportation is the least intensive, medically necessary method; AND

(3) ANY criteria are met in items (a) through (h):

(a) 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

(b) Member cannot safely sit upright while seated in a wheelchair; OR

(c) Member can tolerate a wheelchair but is medically unstable; OR

(d) 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) Member requires isolation due to communicable disease or hazardous material exposure; OR

(f) 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) 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) Member is at risk of harming him/herself or others.

Clinical Criteria for MA Senior Care Options (SCO) Product

Contact the Plan for requests for non-emergency transportation services. After Plan approval, CTS may serve as the Plan's designee to coordinate travel arrangements for covered non-emergent transport and general transport services. The requested transportation must be a component of the member's individualized care plan and applicable medical necessity criteria must be met in EITHER 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. 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:

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, dental, or 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):

Non-Emergency Transportation Services

- (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, dental, or 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:

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, dental, or 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. 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 CTS as the Plan's designee), and the transportation service is covered.

Clinical Criteria for NH Medicaid Product

Contact CTS directly rather than the Plan for requests for covered non-emergent transport and/or medically necessary general transportation services for NH Medicaid members. CTS will coordinate covered and medically necessary transportation 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 NH Medicaid member).

Applicable medical necessity criteria must be met in EITHER item 1 or item 2:

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

Non-emergent sea transport or non-emergent air transport 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):
 - (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
 - (b) Ground transportation is inappropriate to ensure the member's safe transfer; 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

Non-Emergency Transportation Services

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

2. 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) Member requires transportation to and/or from a covered medical, dental, 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), with coverage according to the member's benefit document and applicable New Hampshire regulations (including He-W 572); 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 Transportation:

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

- (1) Member requires transportation to and/or from a covered medical, dental, 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), 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 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. Member is comatose; OR
 - ii. Member requires airway monitoring; OR
 - iii. Member requires cardiac monitoring; OR
 - iv. Member is dependent on a ventilator; OR
 - v. Member requires suctioning; OR

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

c. General Transportation:

General transportation services are covered and considered medically necessary when the Plan's NH Medicaid member requires general transportation services to a covered medical, dental, or 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 CTS (as the Plan's designee) in advance. Requests for transportation services must be submitted to CTS at least 48 hours before the member's non-urgent appointment time. CTS will accept an urgent request for transportation services with less than 48-hour notification when the treating provider's office has validated that the member requires an urgent appointment. CTS must prospectively authorize the mode of transportation and indication for transport, and arrangements must be coordinated by CTS. General transportation services are covered for a NH 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 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 CTS 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 CTS provider authorized to transport the member (with mileage reimbursement for the driver according to CTS guidelines). See the 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

The following transportation services are NOT covered:

Non-Emergency Transportation Services

1. Transportation to and/or from medical appointments, dental appointments, behavioral health appointments, and/or transport to a pharmacy EXCEPT when the specific transportation service is covered and authorized by the Plan or CTS as the Plan's designee.
2. 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 CTS as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
3. Public transportation UNLESS authorized by the Plan or CTS as the Plan's designee as a medically necessary service and component of the member's individualized treatment plan.
4. 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).
5. 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 CTS as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
6. Transport for the purpose of seeking a non-covered service unless authorized by the Plan or CTS as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.
7. Transport for any purpose other than to receive covered healthcare services from a network provider.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (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 utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification

of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan’s medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan’s reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy’s Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

HCPCS Codes	Description: The following transportation codes REQUIRE prior authorization.
	Contact CTS for all non-emergency transport for SCO and NH Medicaid members.
A0021	Ambulance service, outside state per mile, transport (Medicaid only) Plan note: Code is NOT payable for the Plan’s SCO members.
A0100	Nonemergency transportation; taxi
A0110	Nonemergency transportation and bus, intra- or interstate carrier
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems
A0130	Nonemergency transportation: wheelchair van
A0170	Transportation ancillary: parking fees, tolls, other Plan note: Payable by the Plan for NH Medicaid and SCO members if related to emergency ambulance services and is dependent on the primary transportation code.
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS) Plan note: 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.
A0998	Ambulance response and treatment, no transport
A0999	Unlisted ambulance service
S0215	Non-emergency transportation; mileage, per mile Plan note: 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.
T2005	Non-emergency transportation; stretcher van
T2049	Non-emergency transportation; stretcher van, mileage; per mile

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.

Next Review Date

03/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. 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.

Non-Emergency Transportation Services

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.

Appendix: 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

* Effective Date for QHP and MassHealth Products: 01/01/12.

* Effective Date for NH Medicaid Product: 07/01/14.

* Effective Date for SCO Product: 01/01/16.

Effective 06/01/22 policy title changed from Emergency Transportation Services to *Non-Emergent Transportation Services* until 05/31/22. As of 06/01/22, policy title changed to *Non-Emergency Transportation Services*.

Transportation Vendor:

- From 06/01/20 to 06/30/22, One Call Government Solutions, LLC (One Call) managed the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for New Hampshire Medicaid members and Senior Care Options members.
- Prior to 06/01/20 and as of 07/01/22, Coordinated Transportation Solutions, Inc. (CTS) manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for 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	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

Policy Revisions History			
11/01/12	Added Commonwealth Care to list of applicable products (to comply with EOC), removed "Guidelines" from title, updated Summary and References sections, reformatted Medical Policy Statement section, added references to sea ambulance (as appropriate).	Version 3	11/21/12: MPCTAC 12/20/12: QIC
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 New Hampshire Medicaid as an applicable product for this policy and included criteria for 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 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

Policy Revisions History			
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 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.	05/01/15 Version 8	03/18/15: MPCTAC 04/08/15: QIC
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	05/01/18 Version 12	02/21/18: MPCTAC

Policy Revisions History

	Policy Statement and Limitations sections. Revised applicable code list.		
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 Product, and New Hampshire Medicaid Product sections. Updated the Definitions and the Other Applicable Policies sections.	12/01/18 Version 14	09/19/18: MPCTAC
03/01/19	Review for effective date 04/01/19. Administrative changes made to the Medical Policy Statement for 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 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 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	04/01/21 Version 18	01/19/21: MPCTAC (electronic vote)

Policy Revisions History

	Coding section. Administrative change made to the Other Applicable Policies section.		
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 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.	12/01/21 Version 20	11/30/21: MPCTAC (electronic vote)
04/01/22	Review for effective date 05/01/22. Emergency transportation and facility-to-facility transport do not require prior authorization so services removed from the Clinical Criteria for MassHealth Product and Clinical Criteria for New Hampshire Medicaid Product sections. Administrative changes made to the Policy Summary, Applicable Coding, and References sections. QHP was removed as an applicable product from the policy but no material changes to coverage. Revised the policy title.	05/01/22 Version 21	04/20/22: MPCTAC
06/01/22	Review for effective date 07/01/22. Administrative changes made to the Policy Summary, Clinical Criteria for MA Senior Care Options Product, Clinical Criteria for NH Medicaid Product, Limitations and Exclusions, and Applicable Coding sections.	07/01/22 Version 22	06/15/22: MPCTAC
08/01/22	Review for effective date 11/01/22. Removed CPT code A0434 from the Applicable Coding section.	11/01/22 Version 23	08/26/22: MPCTAC (electronic vote)