

UPMC Health Plan POLICY AND PROCEDURE MANUAL

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SUBJECT: Non-Emergent Ambulance Transportation
INDEX TITLE: Medical Management
ORIGINAL DATE: August 1999

This policy applies to the following lines of business: (Check those that apply.)

COMMERCIAL:			
HMO ()	PPO ()		All (X)
Fully Insured ()	Self-funded/ASO ()		
Indiv Short Term ()			
CMS-MA:			
OH ()	WV ()	PA ()	All (X)
HMO(X)	PPO(X)	Specialty Needs Plan (X)	Part D ()
DPW-MA:			
Health Choices /PH(X)Voluntary (X)	Health Choices/BH ()	All ()	
PID-CHIP:			
CHIP (X)			
ANCILLARY:			
UPMC Dental Advantage ()	UPMC Vision Advantage ()	COBRA ()	All ()
WORK PARTNERS:			
Commercial WC ()	Disability Services/TPA ()	Health Promotion ()	All ()

I. POLICY

It is the policy of UPMC Insurance Services Division to address a member's transportation needs in relation to obtaining care that will benefit the member from both a preventive and ongoing health care status. It is recognized that for some members, assistance with arranging transportation may be necessary in order for a member to receive non-emergent care. The coverage for non-emergent transportation will vary by product in which the member is enrolled.

All medically necessary emergency transportation is a covered benefit for all members and is not included in this policy.

II. DEFINITIONS

Case Management - Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost effective manner.

Locality – The term “locality” means the service area surrounding the institution from which individuals normally come for hospital or skilled nursing services.

Medical Assistance Transportation Program (MATP) - MATP is a non-emergency medical transportation service provided to eligible persons who need to make trips to/from a Medical Assistance (MA) reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

- **Medical Need** – To meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the person or their doctor.
- **Medically Necessary** — A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program.

Routine Care - When care is for preventive services or for follow-up of an identified health care condition.

Medical Assistance Definition:

Care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. This care may lead to prevention or early detection and treatment of conditions. Examples of preventive and routine care include immunizations, screenings and physical exams.

Urgent Care - When any illness, injury or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period, and if left untreated, could rapidly become a crisis or emergency medical condition. Additionally, it includes situations such as when a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

III. PURPOSE

The purpose of this policy is to document the process for arranging non-emergency routine and non-emergency medically necessary transportation for our members.

IV. SCOPE

This policy applies to the Commercial, Medicare, and Medicare Specialty Plan, Medical Assistance and Children's Health Insurance Program (CHIP) care management staff.

V. PROCEDURE

A. General Conditions

1. The individual must be eligible with the appropriate UPMC Health Plan products.
2. The transportation by ambulance must be medically necessary i.e., the beneficiary's medical condition is such that other forms of transportation could endanger the patient's health.
3. Transportation needs must not be related to medically necessary emergent health care needs.

B. Responsibility for Non-Emergent Transportation

1. Routine transportation:

- a) UPMC for You Medical Assistance: Non-emergent, routine transportation (excluding Medically Necessary non-emergency ambulance transportation) to and from MA compensable services is to be arranged through and paid by the Medical Assistance Transportation Program (MATP) in the county of the member's residence as defined by DPW. MATP is responsible for the following:
 - Non-emergency transportation to a medical service that is covered by the Medical Assistance Program. This includes transportation for urgent care appointments.
 - Transportation to another county to get medical care as well as advice on locating a train, bus, and route information.
 - Reimbursement for mileage, parking, and tolls with valid receipts, if the consumer used their own car or someone else's to get to the medical care provider.
- b) UPMC for Life and UPMC for Life Specialty Plan: Non-emergent routine ambulance service is covered for Medicare members if medically necessary and meets the established criteria as defined by the Centers for Medicare and Medicaid Services (CMS). The types of situations covered are outlined in item number two (2) and three (3) below.
- c) UPMC for Kids (CHIP): Routine or non-emergent transportation, is not covered by UPMC Health Plan. ***Facility to facility non emergent transfers are a covered benefit if medically necessary.***
- d) UPMC (Commercial): Routine or non-emergent transportation, is not a covered benefit except for facility to facility non emergent transfers if medically necessary.

2. Assisting Members with Routine Transportation

Once the product in which the member is enrolled has been determined the directions to the member are:

a) UPMC Commercial, and UPMC *for Kids* (CHIP) Member

- Non-emergent, routine transportation is not a covered benefit with the exception of facility to facility transfers which is a covered benefit if medically necessary.
- Ambulance transportation for previously scheduled and planned treatments and therapies is not a covered benefit, e.g., dialysis.
- If the member has no other means of transportation, a Care Manager will research for alternative community based resources that may assist the member.

b) UPMC *for You* Medical Assistance Member

MATP will arrange transport to any medical provider of the member's choice in UPMC *for You's* network or an authorized out-of-network provider, except in the case of pharmacy providers. Transportation to a pharmacy provider shall only be provided to a choice of two pharmacies closest to the member's residence or two pharmacies closest to the member's prescribing physician's office (if the prescription was provided at the office visit and is being filled in route from the prescribing physicians office).

When requested, UPMC *for You* must arrange urgent non-emergency transportation for urgent appointments for the Member through the MATP. MATP agencies have been instructed to request verification that a request is for transportation to a Medical Assistance compensable service.

The member's enrollment in MATP will be determined. Direction to the member based on the MATP enrollment status is as follows:

- Enrolled in MATP
 1. Advise member of the process for arranging for transportation services through MATP.
 2. Provide MATP telephone number to member.
 3. Link member to services by making a three (3) way telephone call, as appropriate.
- Not enrolled in MATP
 1. Educate member on the services available through MATP and of the enrollment process
 - Enrollment processing time and processes vary by county.
 - Enrollment may be processed without a member having an appointment for a health care exam or treatment. The member

will be encouraged by the care management staff member to enroll as soon as possible.

- Request for transport may be processed without a completed enrollment. Eligible members may be transported for up to 30 days while completing the enrollment process.
 - 2. Provide the appropriate MATP telephone number to member.
 - 3. Link member to services by making a three (3) way telephone call, as appropriate.
- Non-emergent transportation across county lines is to be provided by the county MATP or through cooperative relationships with neighboring counties.
 - Should the county MATP not be able to accommodate the member's request due to special assistance required from his/her home to the transport vehicle or due to the scheduled appointment day, a denial is to be issued from the MATP and the member is referred to their case worker at the local County Assistance Office (CAO). The County and the CAO MATP coordinator will coordinate to meet the request for exceptional transportation and who is to reimburse for the routine transportation in these circumstances.
 - The care management staff may assist the member with this process by coordinating with MATP and the CAO.
 - If the member has unusual non-emergent transportation assistance needs due to a medical need, the Care Management staff should be contacted for further clinical investigation and possible action as outlined in the Processing Request Due to Medical Need procedure of this policy.
- c) ***UPMC for Life Specialty Plan***
When receiving Medical Assistance benefits, *UPMC for Life Specialty Plan* members qualify to use MATP. The process outlined above for *UPMC for You* members will be followed here. In addition, *UPMC for Life Specialty Plan* members may be eligible for additional non-emergent transportation coverage through the secondary insurance coverage provided by Medical Assistance. Non-covered services under *UPMC for Life Medicare* should be submitted to secondary insurance for possible coverage.

d) ***UPMC for Life and UPMC for Life Specialty Plan***

- Medicare covers non-emergent ambulance transports only to the following destinations:
 - 1) Hospital
 - 2) Skilled Nursing Facility (SNF)
 - 3) Beneficiary's home
 - 4) Dialysis facility for End-Stage-Renal Disease (ESRD)patient who requires dialysis

- A physician's office is not a covered destination
- As a general rule, only local transportation by ambulance is covered. However, payment may be made for an ambulance transfer to an out-of-locality institution if it is the nearest one with appropriate facilities
- Program payment will not be made when other transportation could be utilized without endangering the patient's health, whether such means of transportation is actually available
- A physician's order for a transport does not necessarily prove whether the transport was medically necessary

Note: Wheelchair van transport will only be covered for the same Medicare covered destinations as described above

3. Medically necessary non-emergency ambulance transportation

UPMC *for You* (Medical Assistance), UPMC *for Kids* (CHIP), and UPMC *for Life* Specialty Plan: Non-emergency transportation coverage is provided for the following:

- a) Facility to facility transfers - coordinated by the transferring facility.
- b) Requests for non-emergency transportation assistance may not only be due to a member's lack of access to means of transportation but may be due to other circumstances. This includes:
 - Urgent care is required. If the member is unable to obtain this care, his/her health care status may be in jeopardy and may require emergency care as a result.
 - The current medical condition of the member prohibits transportation by routine means or without professional assistance in getting the member safely from his/her home to a transportation vehicle.
- c) UPMC *for You* is responsible for medically necessary non-emergency ambulance transportation (See exception outlined under Skilled Nursing Facility section)

UPMC Insurance Services Division Medical Management department will determine that a request for urgent transportation should be approved as outlined in the Process/Flow/Criteria section below.

Medical Necessity Requirements UPMC *for Life* and UPMC *for Life* Specialty Plan

Ambulance Services are covered only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. To satisfy the medical necessity requirement, the beneficiary's condition must require **both** the ambulance transportation itself and the level of service provided. In addition:

- The reason for ambulance transport must be medically necessary. The transport must be to obtain a Medicare covered service or return from such a service.
- For nonemergency transportation, medical necessity is satisfied if either (1) the beneficiary is bed-confined and it is documented that other methods of transportation are contraindicated, or (2) the beneficiary’s medical condition, regardless of bed confinement, is such that ambulance transportation is medically required.
 - Bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation – rather, it is one factor considered in medical necessity determinations.
 - For a beneficiary to be considered bed-confined the beneficiary has a condition that makes him bed-confined before and after the ambulance trip. The patient must meet **all** of the following criteria to be deemed “bed confined”:
 - Unable to get up from bed without assistance
 - Unable to ambulate
 - Unable to sit in a chair or wheelchair.
- *Scheduled nonemergency services* are covered if the ambulance provider or supplier, before furnishing the service, obtains a written order from the beneficiary’s attending physician certifying the medical necessity requirements are met. The physician’s orders must be dated no earlier than 60 days before the date the service is furnished
- *Unscheduled nonemergency ambulance transportation* or nonemergency ambulance services scheduled on a non-repetitive basis are covered if the beneficiary’s attending physician certifies within 48 hours after the transport that the medical necessity requirements were met. For a beneficiary residing at home, or a beneficiary residing in a facility who is not under the direct care of a physician, nonemergency services are covered if medical necessity requirements are met without requiring physician certification.
- *Effect of beneficiary death.* In general, if the beneficiary dies before being transported in a ground ambulance, no payment may be made. Therefore, in situations where the beneficiary dies, whether any payment under the ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements.

Ground Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	Payment Determination
Before dispatch	None
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup)	Basic Life Support base rate, no mileage or rural adjustment
After pickup, prior to arrival at the	Medical necessity level of service

receiving facility	furnished
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Skilled Nursing Facility

UPMC Commercial Members in a SNF

Non-emergent, routine transportation is not a covered benefit except for *facility to facility transfers which are a covered benefit if medically necessary.*

UPMC for Life and UPMC for Life Specialty Plan (when under Medicare benefit)

- If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be covered.
- Ambulance transports to and from a covered destination (i.e., two 1 way trips) furnished to a beneficiary who is not an inpatient of a provider for the purpose of obtaining covered medical services are covered, if all program requirements for coverage are met
 - 1) In addition, coverage of ambulance transports to and from a destination under these circumstances is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient.
- In order for the Medicare part A Skilled Nursing Facility (SNF) benefit to cover transportation via ambulance the regulations specify that the ambulance transportation must be medically necessary.
- SNF Ambulance services that are not part of the covered benefit:
 - Initial ambulance trip that brings a beneficiary to a SNF
 - Ambulance trip to discharge beneficiary from a SNF when it occurs in connection with:
 - An inpatient admission to a Medicare participating hospital or Critical Access Hospital (CAH)
 - A trip to the beneficiary's home to receive services from a Medicare-participating home health agency
 - A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services
 - A discharge or other departure from the SNF that is not followed by readmission to that or another SNF by midnight of the same day
 - Transport from the SNF to an outpatient hospital for:
 - Cardiac catheterization
 - CT scan
 - MRI services
 - Ambulatory surgery involving the use of an operating room
 - Emergency room services
 - Radiation therapy
 - Angiography

- Lymphatic and venous procedures
 - The return trip from the hospital to the SNF
 - Transport to and from dialysis

UPMC for You

- Under the Medicaid program it is the responsibility of participating nursing facilities to provide medically necessary non-emergency transportation for their Medicaid nursing facility residents. The nursing facility shall not bill the Medicaid resident for this service. This includes, but is not limited to transportation to and from :
 - doctor appointments
 - dentist appointments
 - partial hospitalization treatment programs
 - non-emergency ambulance transportation from a nursing facility to a hospital and from a hospital to a nursing facility

C. Process Flows/Criteria

Processing Request Due To Medical Need

Ambulance services are coordinated through UPMC contracted ambulance provider/supplier except in the Lehigh Capital region.

Processing Request Due To Medical Need by a non ambulance provider for UPMC for You (Medical Assistance) and UPMC for Life Specialty Plan when receiving medical assistance benefits: Non-emergency transportation coverage is provided for the following:

1. Requests for non-emergent transportation assistance to a provider's office or facility due to a medical necessity may be referred to the Care Management staff to assist in locating transportation assistance as outlined in this policy.
2. The Care Manager will:
 - a) Document the request in the Medical Management Department's care management documentation system.
 - b) Attempt to contact the member and provider to obtain information regarding the needed care and appointment dates and location.
 - c) For Medical Assistance and Specialty Plan members: Identify the applicable MATP or county Medical Assistance Office.
 - d) Contact the member and referring provider and inform them of options and any arrangements made.

Document the information and arrangements made in the care management documentation system.

D. Records Retention

Records Retention for documents, regardless of medium, are provided within the UPMC Health System Policy Records Retention, Management and Retirement, and as indicated in the UPMC Insurance Services Division Policy and Procedure Records Retention.

E. Quality Audit

Quality Audit may monitor policy compliance or billing accuracy at the request of the UPMC Health Plan's Technology Assessment Committee or the Benefits Reimbursement Committee.

Disclaimer:

UPMC Health Plan medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of UPMC Health Plan and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

UPMC Health Plan reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

These policies are the proprietary information of UPMC Health Plan. Any sale, copying, or dissemination of said policies is prohibited.