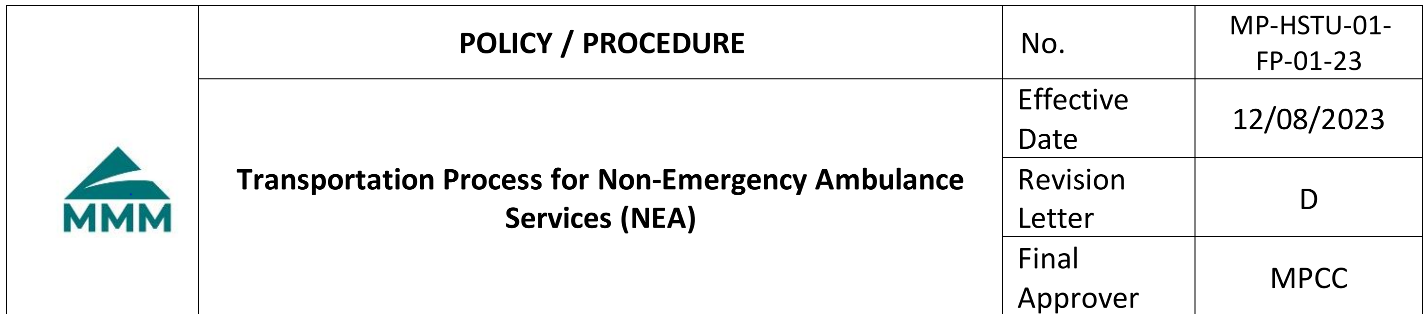

MMM	POLICY / PROCEDURE	No.	MP-HSTU-01-FP-01-23
	Transportation Process for Non-Emergency Ambulance Services (NEA)	Effective Date	12/08/2023
		Revision Letter	D
		Final Approver	MPCC

1.0 Purpose

To define the way MMM Holdings LLC., prior to the provision of transportation services validates members medical and social needs. Determine the adequate transportation according to the alternatives provided by the plan for Non-Emergent Ambulance (NEA).

2.0 Scope

This document applies to all departments of MMM Holdings LLC., under the Medicare Advantage Business Plan, for all policies and procedures are developed as part of the Company's daily operations.

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3.0 Policy

Prior to providing this type of transportation, member and or providers shall obtain a prior authorization for Non-Emergency Ambulance (NEA). These services/trips are not discount from the transportation benefit. These services are evaluated by members eligibility, social needs, and level of care and using as reference the coverage criteria as defined in the Medicare Benefit Policy Manual Chapter 10. Practitioners are given the opportunity to discuss any denial decision of an organization determination with a Plan physician reviewer.

The organization:

- Treats every case in a manner that is appropriate to its medical social needs or urgency and does not systematically take the maximum time permitted for service-related decisions.
- Do not discriminate to cover services, do not receive any compensation.
- Perform determination only based on medical social needs, and do not reject to provide reimbursement, or denied services due to religious believes.
- Respects the right of all individuals to health, regardless of their needs or circumstances, with a genuine commitment to reduce healthcare disparities and enable health equity for all. (CMS Framework for Health Equity 2022–2032).

4.0 Definitions

1. Preauthorization - The review of the transportation proposed by a participating or non-participating professional provider, for select list of services, before the provision of the services.

2. Non-Emergent Ambulance (NEA)- Level of transportation for non-emergency ambulance that requires preauthorization process based medical and social needs established guidelines or policies and eligibility.

3. Authorized Representative: An individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise state, the representative will have all the rights and responsibilities of an enrollee or party in obtaining a transportation, filing a grievance, or in dealing with any of the levels of the appeals process.

5.0 **Responsibilities**

5.1 The Chief Medical Officer (CMO) is responsible for the medical activities of the medical directors and providers, while ensuring appropriate use of medical guidelines in the operations.

5.2 The Chief Operational Officer (COO) is ultimately responsible for the Care Management process, while designating the oversight of the operations to the Health Services Pre-Authorization Director.

5.3 The Director, Manager and Supervisors (as applicable) are responsible for the day-to-day operations and establishes improvement plan as deemed appropriate and are responsible for supervising the staff and ensuring proper execution of the policy and procedure.

5.4 The Transportation Unit, Delegated Entity, Care Management Program, Discharge Planning staff are responsible for putting into action the policy and procedure and maintaining case documentation available for audit process, and responsible for processing organizational determination requests within Centers for Medicare & Medicaid Services (CMS) and other regulatory agencies and Administración de Seguros de Salud de PR (ASES) and mandated timeframes and for authorizing services that meet established criteria.

- For the Non-Emergent Ambulance (NEA) service the Transportation staff and Delegated Entities are responsible of collecting all the data and presenting the case that do not meet with the guidelines, social needs, member benefit or policies to Medical Review for final determination.

5.5 The Medical Reviewers are responsible for evaluating the requests that do not meet with medical and social needs established guidelines or policies. Medical Reviewers are the only personnel responsible for making adverse clinical determinations.

5.6 Under the advisement of the Corporate Medical Reviewer, the Preauthorization Management is responsible of approving or amending the following:

- Selecting procedures and levels of care requiring preauthorization
- Developing and approving preauthorization guidelines for Non-Emergent Ambulance (NEA)
- Monitoring over and underutilization within the network
- Identifying intervention strategies to improve compliance with the guidelines.

5.7 The requesting physicians are responsible for submitting transportation requests for Non-Emergency Ambulance to the Transportation Unit via fax, electronic transmission or by calls on behalf of member; members, or their authorized representatives, also may submit a request in writing by post mail, email, by calling or walking into a Regional Office.

5.8 The Information Technology Department is responsible for maintaining the information systems used to process all request.

6.0 **Procedures**

6.1 The Transportation Unit Staff receives transportation services request through the following channels:

❖ Provider submits requests by fax, email, and electronic transmission or by phone on behalf of member; members, or their authorized representatives, also may submit a request in writing, by email, by calling, or walking into a Regional Office.

❖ If a request is received by call, writing by post mail or by email from a person claiming to be a representative, but this person does not provide the valid representative documentation to show is an authorized representative to act on the enrollee's behalf.

❖ The request is uploaded in the Preauthorization application; the staff makes reasonable attempts to call the member and validate the information received.

6.2 The Physician or member submits transportation request including member information, medical necessity, or social needs. The physician or member/representative indicates whether the request is standard or expedited based on the member's health condition needs.

6.3 If the member/representative or physician submits a transportation request by phone they must include member name, address, telephone number, member ID number, diagnosis codes (ICD-Active) for all applicable diagnosis, type of transportation (HCPCs code), date, hour, place and provider of appointment name and his/her telephone and fax numbers. If the case needs additional information or results to validate member condition, they are asked to submit information by fax system or by electronic transmission in the same day. For members who submit a written request for transportation, the Health Services staff works with the member and their physician to obtain the necessary information to create a case.

6.4 If the physician submits a request for transportation by fax or electronic transmission, the Transportation Unit Staff receives the requests and verifies if the required information is complete for processing. Required information should be legible and should include member name, address and telephone number, member ID number, diagnosis codes International Classification of Diseases (ICD- Active) for all applicable diagnosis, type of transportation (CPT code), date, hour, place and provider of appointment, requested provider, Primary Care Physician (PCP) name and his/her telephone and fax numbers. Requests must be signed by the requesting provider including his/her license number.

6.5 All requests with exception of the electronic request are uploaded into the preauthorization system using the applicable status of expedited or standard. The information above is necessary to create a case, and should any be missing, a fax is sent to the provider indicating that the requesting physician is responsible for sending the missing information immediately. If no information is received continuous follow up will be performed, daily to gather the information before considering a determination or denial.

6.6 The Transportation Unit Staff performs the review of the request using guidelines establish in this policy:

Guidelines:

(Reference: 10.2.3 - Medicare Policy Concerning Bed-Confinement-Medicare Benefits Policy Manual, Chapter 10 – Ambulance Services)

To comply for the service of Non- Emergency Ambulance Transportation, a phone call is made to the member to make the questions below. If no contact is made, the Transportation Staff can review system history to validate member’s condition.

Member must comply with one of the following conditions:

A beneficiary is bed-confined if he/she is:

- Unable to get up from bed without assistance
- Unable to ambulate
- Unable to sit in a chair or wheelchair
- Status bedridden
- Oxygen Use in a continuous way
- Have an intravenous therapy in a continuous way
- Have a tracheotomy
- Use of equipment that requires assistance from qualified personnel in ambulance
- Any current health condition that requires ambulance transportation

If during interview it is identify that the member walks, is independent in activities of daily living and does not use oxygen, intravenous or any other equipment that requires assistance from qualified personnel in ambulance refer to Medical Review with all the collected data for final determination.

Applicable codes:

Codes	Description
A0428	Amb. Serv / Basic Life Support
A0999	Bariatric Ambulance

To comply for the service of bariatric ambulance transportation, the member's weight must be 350 pounds or more, height and physical constitution are also taken in consideration.

6.7 If the request for transportation requires additional information, the staff searches in other sources of information like previous cases in systems and will proceed to gather additional medical social information. Calls to the requesting physician and/or member to obtain additional information are performed, as well as fax requests to the provider are made. For expedite requests interventions must be completed in a time frame of 72 hours. For standard requests interventions must be completed and or before the day 14. If additional information is obtained, staff initiates the review process. If no information can be obtained the staff sends the case to Medical Reviewer for final determination.

6.8 All request lacking clinical information necessary to decide undergoes an outreach process. This process is done during regular working hours. For standard and expedited requests, the plan performs a minimum of 1 attempt to obtain necessary information. The outreach process must ensure compliance with timelines.

For all request if the first outreach attempt is unsuccessful, a letter is sent immediately to the requesting physician stating type of clinical information required. If necessary, calls to member to obtain additional information are made.

6.9 All requests for expedited determinations must be completed within 72 hours of receipt of the request. Notification of the determination is communicated to the member orally and in writing within the 72 hours of receipt of the request. Requesting and/or servicing provider receive the notification by auto-fax as soon as the determination is made.

6.10 All standard requests from non-contracted requesting providers must be evaluated and determined under the same scope and/ or procedure as one contracted provider request. All expedite requests from non-contracted requesting providers must be evaluated and completed under the same scope and/ or procedure as one contracted provider.

6.11 Medical Director is responsible for making a last call to the requesting provider in order to gather the needed information before the adverse decision is made in all cases that have gone through the Waiting Information process, however this will not be necessary in cases where that the determination be a favorable one.

6.12 All requests for standard determinations must be completed within 14 days after receipt of the request. Notification of the determination is communicated to the member in writing within the 14 days of receipt of the request. Requesting and servicing provider receive the notification by fax within the timeframe established.

6.13 The Medical Reviewer reviews request when services do not meet established medical or social needs criteria.

6.14 In cases where a denial determination is made by a Medical Reviewer the following takes place:

- ❖ The staff changes status to deny in the system.
- ❖ The denial notification indicates the service denied reason, reference to criteria/guidelines used, notification that the member may request a copy of the guideline/criteria, and a copy of appeal rights. The Fax cover sheet for the denial notice sent to the prescribing physician includes information on how to contact the Medical Reviewer for a discussion regarding the denial.
- ❖ Notification takes place within the established time frames per CMS Guidelines (72 hours for expedited requests and 14 calendar days for standard requests), or as expeditiously as the member's health requires. After MMM Holdings LLC., notifies the member of its expedited determination verbally a written notification is mailed to the member or

their representative, within 3 calendar days of the verbal notification. Requesting and Servicing Providers are also notified in writing by fax. If the physician, member or authorized representative disagrees with the denial determination, he/she may submit a request for reconsideration per established policies and procedures.

6.15 In cases approval determination, a notice is generated by the system in the timeframe established by CMS. For expedited cases the member is also notified orally within the 72 hours.

6.16 Each determination is based on medical, social needs and member's plan benefit package.

6.17 Preauthorization processing is tracked through the online application reports:

- ❖ Authorization's turnaround times
- ❖ Percentage authorization category
- ❖ Staff productivity

6.18 The Management of the Unit or delegated representative monitors online application reports in order to ensure compliance with CMS time frames, as well as through weekly departmental audits to evaluate documentation and compliance with requirements.

6.19 This process can be delegated to Vendors, which are trained, monitored, and have established metrics.

6.20 Corrective action plans are implemented as necessary in order to ensure compliance with policies and procedures. The Senior Manager of the Compliance Department and the Unit Management provides guidance during the process.

Discharge Transportation (To be assessed by Coordinator)

All ambulance for hospital discharge requires a medical order and supporting documentation that must be send to the plan thru facsimile. The trips will not be discounted of the benefit. The period of the discharge services will be for 72 hours.

The hospital staff are responsible for sending the requested documentation directly to the plan by fax.

The Transportation staff is responsible of validating eligibility, compliance with guidelines, social needs, or medical criteria the ambulance transportation with the hospital staff.

1. If the information is complete and the member meets criteria, proceed to approve, and coordinate with a servicing provider.

2. If the member does not meet social needs, guidelines o medical criteria, refer to the Medical Director with all the data collected for final determination.

After Hours Discharge Transportation (To be assessed by Delegated Entity, Telemedik)

After the MSO working hours, the transportation request process is processed thru the Telemedik Call Center if it enters the schedule of:

- Monday through Thursday from 3:30 p.m. to 7:29 a.m. of the next day
- Fridays and holidays from 3:30 p.m. to Monday at 7:29 a.m. of the next day

All requests for discharge during the on-call period must be evaluated regardless plan coverage. The trips will not be discounted of the benefit. The period of the discharge services will be for 24 hours. The hospital staff must contact Telemedik Call Center during the on-call period at the phone number 1-866-517-0703 with the following information:
Required for request:

1. Name of the hospital contact that has all the information relevant to the request for transportation and position that occupies.
2. Name of the hospital where the patient is admitted.
3. Date and time of discharge.
4. Patient's destination (residence, custodial home, office, other hospital).
5. Type of transport: regular car, wheelchair van or ambulance.
6. Member Health Information:
   - ✓ Provider license number
   - ✓ NPI and signature
   - ✓ Member's full name
   - ✓ Member ID number
   - ✓ Medical Diagnostics
   - ✓ Type of transportation required

The hospital staff are responsible for sending the requested documentation directly to the plan by fax. If the medical order and supporting documentation are not received, the plan will proceed to issue an adverse determination of the service. Telemedik staff are responsible of validating eligibility, compliance with guidelines, social needs or medical criteria and type of transportation required.

1. If the documentation is not received, the outreach process will start, and this is performed on 3 consecutive days from the day where interventions began.
2. After the outreach process is completed and the documentation is received, proceed to verify Name, correct member ID number validate that the member is active in the plan and proceed to complete the case in system.
3. If the documentation is not received, proceed to present the case to Medical Director for final determination and proceed to complete the case with the recommendation.

Non-Emergent Air Ambulance (To be assessed by Coordinator; final assess by MR)

Verify the following information: Name, correct member ID number, type of transportation required, to be eligible the member must be active in the plan. The trips will not be discounted of the benefit. Medical orders are always required for Non-emergent Air Ambulance with a valid effective date (no more than 90 days of expedition) and may include Physician's name address, license, signature, NPI.

Identification Process:

The evaluation of air ambulance transportation services can be identified through the following sources:

a. Primary Care Physician Referral (Ambulatory)
b. Concurrent Review Nurses (Inpatient)
c. Hospitals (Discharge Planning Unit)
d. Internal Process (PAU, DPU and Case Management)
e. After Hours Services
f. USA Hospitals Discharge Planners

1. The required transportation services will be created in the online system application.

2. The Transportation services are coordinated for the following levels:

   a. Puerto Rico Hospital to Hospital Transfers
   b. Out of Puerto Rico Hospital to Hospital Transfers
   c. Puerto Rico to USA
   d. USA to Puerto Rico

3. There are two categories or air ambulance services: fixed wing (airplane), and rotary wing (helicopter) aircraft.

   a. Fixed Wing (airplane), according to Medicare is furnished when the beneficiary's condition requires rapid transport to treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance is inaccessible by a ground or water ambulance vehicle.

   b. Rotary Wing Air Ambulance (Helicopter), according to Medicare is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility; and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance us inaccessible by a ground or water ambulance vehicle.

4. The Air Ambulance request will be reviewed according to established criteria for these types of Transports, according to Centers for Medicare and Medicaid, the following criteria should be considered for Air Ambulances:

Scenarios Criteria:

a. The beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulances; and either

b. The point of pickup is inaccessible by ground vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the United States of America.

c. Great Distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities.

d. Hospital to Hospital Transfers, if the medical appropriateness criteria are met, that is, transportation by ground ambulance would endanger the beneficiary's health and the transferring hospital does not have adequate facilities to provide the medical services required by the patient. If a hospital can treat the patient, and the patient and/or patient's family prefer a specific hospital or physician air ambulance service will not be covered by the Medical Plan.

e. The Medical Plan will not cover Air Ambulances for nursing facilities, physicals office of beneficiary's home.

Medical Reasonableness:

Medical reasonableness is only established when the beneficiary's, condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival of seriously endangers the beneficiary's health. For Example:

- Intracranial bleeding –requiring neurosurgical intervention
- Cardiogenic shock
- Burns requiring treatment in a burn center
- Conditions requiring treatment in a Hyperbaric Oxygen Unit
- Multiple Severe injuries
- Life – Threatening trauma

5. Those cases considered as an Emergency in which the members life depends of the Air Ambulance Transport will not require Medical Plan Prior Authorization, Servicing Providers will submit the claim with the medical documentation that supports the Emergency Air Ambulance to the Claims department.

6. All Air Ambulances requests will be evaluated by the Medical Director who will determine if the Air Ambulance is approved or denied. The Medical Director can request more documentation from the requesting provider before the case is determined. The requesting providers should submit the medical reasonableness that justifies that a commercial flight and/or ground transport is not appropriate for the member's health status. Request also requires submission of quotation of the

cost of the transportation service.

7. Transportation authorization requests that do not meet the criteria will be denied according to Health Services Department established process.

8. The Transportation Unit staff will notify the provider and the vendor of the approval and will coordinate the service in a timely manner to assure member access to health services and to avoid treatment interruptions.

   The Transportation staff will notify the member of the approval and will make the coordination through the Health Services Department prior authorization process.

   Applicable codes:

Codes	Description
A0430	Fixed Wing (Airplane)
A0431	Rotary Wing Air Ambulance (Helicopter)

RELATED POLICIES AND PROCEDURES

- HSTU-02 Transportation Process Policy for Non-Emergency Non-Ambulance Services (NENA)
- Medicare Benefits Policy Manual, Chapter 10 – Ambulance Services (Rev. 243, 04-13-18)
- L37697 - Emergency and Non-Emergency Ground Ambulance Services **Retirement Date** 02/09/2023

7.0 **Document Approvals**

Role	Position	Name of Approver	Approval Signature	Date Approved
Department Head	Chief Medical Officer	Dr. Waldemar Ríos	Signature on File	01-01-2021
Department Head	Chief Medical Officer	Dr. Waldemar Ríos	Signature on File	09-28-2022
Department Head	Chief Medical Officer	Dr. Waldemar Ríos	Signature on File	12-11-2023

8.0 **Medical Policy Clinical Committee Revision History**

Date	Version	Comments
12/08/2023	Final	Approved by Medical Policy Clinical Committee (MPCC)

9.0 **Revision History**

Effective Date	Rev Letter	Document Author	Description of Change
01-01-2021	A	Liz Román	Initial Release due to Transportation Unit new identity.
09-28-2022	B	Liz Román – Evelyn Rivera	Add discharge from hospital process.
11-07-2023	C	Liz Román – Evelyn Rivera	Policy section - CMS Framework for Health Equity 2022–2032 Reference was added. Changes in section 6.1 – transportation services request channels were added; section 6.7 – wording first intervention was eliminated; section 6.8 - Outreach process – minimum attempts. Changes in section 5.0 Responsibilities were made.
12-11-2023	D	Liz Román – Evelyn Rivera	Minimum changes in wording of section 6.6 under Guidelines, by adding the references: Medicare Benefits Policy Manual, Chapter 10 – Ambulance Services and L37697