



Easy Choice Health Plan

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Transportation for Care Coordination

Policy Number: HS-314

Original Effective Date: 12/3/2015

**Revised Date(s): 11/3/2016; 9/7/2017; 9/6/2018;
12/6/2018**

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Medicaid and low-income Medicare Advantage members often experience significant socioeconomic challenges that may adversely impact their ability to adhere to a practitioner-prescribed medical/behavioral treatment plan. Given the complexities of their medical condition and other social and economic issues, such members would benefit from coordination of care through telephonic and/or face-to-face care management. As part of this coordination of care, care managers will engage community resources to address the myriad of environmental issues to positively improve the overall quality and health of the member.

In addition, the health plan may implement directed quality improvement initiatives that require the coordination and use of community resources such as transportation services that may or may not be a component of the member's benefit structure. These quality initiatives strive to directly reduce care gaps, improve the health outcome of members and avoid unnecessary hospitalizations.

POSITION STATEMENT

Applicable To:

- Medicaid
- Medicare
- Medicare – Maine, New York, Texas (see information below for Members with End Stage Renal Disease)

Step 1: Determine if Transportation Request is Urgent or Routine

Examples of urgent transportation include:

- EMS activated transportation to the emergency room
- 9-1-1 calls
- Facility to facility transfers
- Hospital to home

Examples of prescheduled (routine) transportation include:

- Routine transportation
- To and from provider visits
- Dialysis

NOTE: Post service requests will be reviewed for Medical Necessity and not subject to administrative denials.

All requests for transportation are documented in the medical management platform. If the request is for urgent transportation, the request will be approved and a *Prior Auth Approval Fax Template* is sent to the Requesting Provider, Ordering Provider, Treating Provider and Facility, as appropriate.

Step 2: Determine if Routine Transportation is a Covered Benefit Under the Member's Specific Health Plan

For members with a transportation benefit, proceed to Step 3.

For members without a transportation benefit under the health plan but with transportation benefits *covered by another entity*:

- The Provider shall contact the other entity to obtain authorization for Transportation; **AND**
- The health plan authorization Request is closed and necessary fields are updated in the medical management platform; **AND**
- A fax is sent to the Provider utilizing the Redirection to other Payor / Vendor fax templates.

For members without a transportation benefit or who have exhausted their benefit limitations, proceed to Step 4.

Step 3: Determine if the Member's Line of Business has a Transportation Vendor

For markets with a transportation vendor, WellCare will call the Requesting Provider to attempt redirection to the Vendor. If redirection to the vendor is successful, the authorization is closed and a fax is sent to the Provider.

For markets without a transportation vendor, WellCare determines how many rides the member has had by calculating information in the medical management platform. For members within benefit limitations, the request will be reviewed for medical necessity.

Step 4: Review for Medical Necessity

A Medical Director reviews for medical necessity based on the need for transportation. This applies to members who do not have a covered benefit, when a Member has exhausted their benefit limitations, or when a member is identified as having a care gap as part of a Quality Improvement initiative. If the medical director determines that routine transportation is medically necessary for the member's ongoing coordination of care **and** will address,

improve or avoid deterioration of the member’s current medical and behavioral health condition, the medical director will approve the request. The medical director will direct the health plan staff to first utilize the health plan’s Community Assistance Line (CAL) for available community transportation resources.

The nationwide, toll-free CAL helps connect people to social services including financial, food, education and utility assistance, transportation, disability and homeless services, support groups and child care. WellCare’s CAL currently operates Monday through Friday, from 9 a.m. to 6 p.m. EST at 866-775-2192 (main line) or 855-628-7552 (video relay).

If there are no available community resources to address the member’s transportation needs within a timely manner, the health plan staff will outreach to available transportation vendors in the member’s market area to provide the transportation services for coordination of care or as component of a quality improvement initiative.

Universal American (UAM) Only (Medicare – Texas, Maine, and New York)

Coverage for transportation related to End Stage Renal Disease **is a covered benefit** when the following are met:

- Member cannot reach appointment for dialysis via family, friend, or other caregiver; **AND**
- Member is unable to secure transportation via the Community Advocacy Line.

CODING

CPT Codes – No applicable codes.

Covered HCPCS Codes

- A0021 – A0999** Transportation services including ambulance
- S0215** Nonemergency transportation; mileage, per mile
- T2001** Nonemergency transportation; patient attendant/escort
- T2002** Nonemergency transportation; per diem
- T2003** Nonemergency transportation; encounter/trip
- T2004** Nonemergency transportation; commercial carrier, multipass
- T2005** Nonemergency transportation; stretcher van
- T2007** Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments
- T2049** Nonemergency transportation; stretcher van , mileage; per mile

Covered HCPCS Modifiers

- D** Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes
- E** Residential, domiciliary, custodial facility (other than 1819 facility)
- G** Hospital-based ESRD facility
- H** Hospital
- I** Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- J** Free standing ESRD facility
- N** Skilled nursing facility (SNF)
- P** Physician’s office
- R** Residence
- S** Scene of accident or acute event
- X** Intermediate stop at physician’s office on way to hospital (destination code only)

ICD-10 Codes – No applicable codes.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member’s benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
12/6/2018	• Approved by MPC. Inclusion of Universal American (UAM) criteria for transportation for ESRD patients.
9/6/2018, 9/7/2017, 11/3/2016	• Approved by MPC. No changes.
12/3/2015	• Approved by MPC. New.