Aetna Better Health® of Louisiana

Appendix E: Medical Transportation

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Section 1: Covered Services Overview, Criteria, and Limitations

ABHLA covers varying levels of transportation for our members:

- Emergency Ambulance Transportation
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- Value Added Routine Transportation
- Ambulance Treatment-in-Place

All transportation services have separate requirements and criteria. Please see the corresponding section for each type of service.

Transportation (Appointments vs Emergencies)

If the member has an emergency and has no way to get to the hospital, call 911 for an ambulance. If the member does not have transportation, we will cover transportation to medically covered services by Aetna Better Health of Louisiana. We will also cover transportation to Medicaid covered services such as dental care. We use a transportation vendor for member transportation needs. Transportation is provided to the visit and to the pharmacy, only when the member goes directly to the pharmacy immediately following the appointment.

There is no limit on the number of trips provided.

Transportation appointments must be scheduled three 48 hours in advance. Reservations can be made up to thirty (30) days in advance. Our transportation vendor will assist with ongoing transportation needs for services such as dialysis, or other re-occurring treatments. When making reservations, keep in mind that members should not arrive more than one hour before their scheduled appointment.

To schedule a ride, call our transportation vendor at **1-877-917-4150, TTY 1-866-288-3133**.

Please have these details ready when calling our transportation vendor:

- Name of the provider
- Provider's address
- Provider's telephone number
- Time of appointment
- Type of transportation needed (e.g., regular car, wheelchair-accessible van)

Contact Information

For emergency transportation, please call **911**.

For NEMT, NEAT, and Value Added Transportation scheduling, please contact Meditrans, 7AM-7PM Monday-Friday CST:

- Reservations (48 hours in advance): **1-877-917-4150**
- 24-Hour Ride Assistance: **1-877-917-4151**
- TTY: **1-866-288-3133**

Section 2: Emergency Ambulance Transportation

Emergency Transportation

ABHLA does not require prior review or authorization for emergency ambulance transportation. Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part

A member may also require emergency ambulance transportation if they are psychiatrically unmanageable or need restraint. ABHLA requires ambulance providers to retain documentation appropriately supporting at least one of the criteria was met and the enrollee would be susceptible to injury using any other method of transportation. An ambulance trip which does not meet at least one of the criteria would be considered a nonemergency service and must be coded and billed as such.

Air Transportation

Emergency air transportation does not require prior authorization. Providers must submit supporting clinical information with the claim for post-payment medical necessity review.

Prior authorization is required for non-emergency air ambulance transportation. Providers may submit a request for prior authorization through ABHLA's online Availity portal, fax, or phone. ABHLA will cover air ambulance services only if:

- Speedy admission of the member is essential and the point of pick-up of the enrollee is inaccessible by land vehicle or;
- Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate services

Section 3: Non-Emergency Ambulance Transportation (NEAT)

NEAT is transportation provided by ground or air ambulance to a member to and/or from a Medicaid covered service, including carved-out services, or VAB when no other means of transportation is available, and the member's condition is such that use of any other method of transportation is contraindicated or would make the member susceptible to injury.

Please note that **ALL** NEAT trips will require a completed, valid **Certification of Ambulance Transportation** (CAT). The beneficiary's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition, which necessitates ambulance services. The date range on the CAT must be no more than 180 days. A single CAT will be utilized by ABHLA for all the member's transports within the specified date range. ABHLA will not require a new CAT from the certifying authority for the same member during this date range.

Aetna requires the ambulance provider to verify member eligibility, the originating or destination address belongs to a medical facility, and a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the ambulance provider prior to transport reimbursement. ABHLA will reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with ABHLA or the transportation broker prior to reimbursement. Mileage must be reimbursed in accordance with the type of service indicated by the licensed medical professional on the Certification of Ambulance Transportation.

Medical Necessity Criteria

ABHLA's standards of Medical Necessity for Non-Emergency Ambulance Transportation are as follows:

- Medical necessity for ambulance service is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, no payment will be made for ambulance services.
- ABHLA considers the medical necessity requirement met when the beneficiary is bed-confined before the trip and expected to remain so after the trip. A beneficiary is bed-confined if he/she is:
    - unable to get up from a bed without assistance;
    - unable to ambulate; and
    - unable to sit in a chair or wheelchair.

Note that the term "bed confined" is not synonymous with "bed rest" or "non-ambulatory."

Scheduling Services

To schedule NEAT, Members can call MediTrans at 1-877-917-4150, Monday to Friday from 7 a.m. to 7 p.m., to set up routine transportation. Rides must be set up 48 hours prior to the appointment.

Providers may also reach MediTrans through email at **ABHLA@meditrans.com** or by phone at 1-844-349-4326. The Nonemergent Transportation Request Form can be found on our provider portal and can be emailed to MediTrans or faxed to 1-337-366-6760. MediTrans may be contacted 24/7 for hospital discharges.

If transportation is scheduled through the ABHLA, ABHLA will verify enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by ABHLA or the transportation broker prior to transport before a transport is scheduled. Once the trip has been dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport.

The Certification of Ambulance Transportation form is located at **www.lamedicaid.com**.

Section 4: Non-Emergency Transportation

Non-Emergency Medical Transportation (NEMT)

NEMT is transportation provided to Medicaid enrollees to and/or from a Medicaid provider for a Medicaid covered service, including carved-out services and VAB, when no other means of transportation are available. NEMT does not include transportation provided on an emergency basis, such as trips to emergency departments in life threatening situations.

Covered Services

ABHLA authorizes NEMT for the least costly means of transportation available to and/or from a qualified provider of routine or specialty care within the enrollee's transportation service area.

Scheduled trips in which no transportation of the enrollee occurs are not billable.

Reimbursement to transportation providers shall be no less than the published Medicaid fee-for-service rate in effect on the date of service, unless mutually agreed to by ABHLA and the transportation provider in the provider agreement.

Transportation to and from appointments for Medicaid covered services appointments and to extra services we offer such as adult dental care or a trip to the pharmacy after your appointment.

Exceptions: Enrollees may seek medically necessary services in another state when it is the nearest option available. All non-emergency out-of-state transportation must receive prior approval from ABHLA.

Commercial Air Transportation for Out-of-State Care

Transportation on commercial airlines may be approved for out-of-state trips when no comparable services can be provided in Louisiana, and the risk to the enrollee's health is grave if transported by other means. The transportation broker shall contact LDH if it determines that air travel is required, as commercial air transportation requires prior authorization. All out-of-state medical care must be prior authorized by the LDH fiscal intermediary. Transportation may be included in the prior authorization for medical services. Approval shall be contingent on the treating physician's confirmation that there are no negative impacts to the health and safety of the enrollee by utilizing commercial air transportation.

Air travel for the enrollee plus a maximum of one attendant, if medically necessary or if the enrollee is a child, shall be reimbursed for the lowest, refundable, coach/economy class fare. Upgrades (e.g., fare class or seat) and additional costs (e.g., in-flight refreshments) shall not be reimbursed.

Value Added Routine Transportation

Trips to the pharmacy are covered through value-added benefits (VABs). Effective 1/1/2023, Aetna will provide transportation to all applicable value-added services offered. Transportation services will be provided for activities such as job interviews, job training, trips to grocery stores or food banks, faith-based events, and accessing community support services not otherwise covered. Requests for transportation require 48 hours' advanced notice; trips scheduled with less than 48 hours' notice are not guaranteed, but an attempt will be made to provide the service if appropriate staff is available. Transportation to VABs is offered according to the benefit limitations. Limited to 10 round trips (20 one-way trips up to 60 miles total per round trip).

Section 5: Ambulance Treatment-in-Place (TIP)

The treatment-in-place service consists of a treatment-in-place ambulance service plus a treatment-in-place telehealth service. Each paid treatment-in-place ambulance service must have a corresponding paid treatment-in-place telehealth service and each paid treatment-in-place telehealth service must have a corresponding paid ambulance TIP service or paid corresponding emergent transport to a hospital facility.

Treatment-in-Place Ambulance Claim:

The treatment-in-place ambulance service must be separately billed from the treatment-in-place telehealth service. The ambulance provider's NPI must be enrolled as an ambulance service billing provider with the entity to whom the claim will be submitted (fee-for-service Medicaid or the MCO).

Supply codes A0382 and A0398 are payable but mileage (A0425) and other ambulance transportation services are not payable. If a treatment in place claim is submitted with mileage, the entire claim document will be denied. If an unpayable code, that is not mileage, is submitted on a treatment in place claim, only the line with the unpayable code should be denied.

Claims must indicate treatment-in-place destination code "W" in the destination position of the origin/destination modifier combination. TIP claims without Modifier "Y" to in the emergency indicator field will be denied by ABHLA.

Valid Treatment-in-Place Ambulance Claim Modifiers:

Modifier	Origination Site	Destination
DW	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Tx-in-Place
EW	Residential, domiciliary, custodial facility (other than 1819 facility)	Tx-in-Place
GW	Hospital based ESRD facility	Tx-in-Place
HW	Hospital	Tx-in-Place
IW	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport	Tx-in-Place
JW	Freestanding ESRD facility	Tx-in-Place
NW	Skilled nursing facility	Tx-in-Place
PW	Physician's office	Tx-in-Place
RW	Residence	Tx-in-Place
SW	Scene of accident or acute event	Tx-in-Place

If a patient being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both the treatment in place ambulance service and the transport to the emergency room. In that case, the **ambulance provider shall bill only for the emergency department transport**.

Requests for consideration or reconsideration of these claim denials (edit 90/100) for multiple treatment in place and treatment in place and transport claims rendered on the same date of service for the same recipient, should be submitted with a **Prehospital Care Report from the ambulance service provider's system** demonstrating the services were rendered for different occurrences. Aetna Better Health of Louisiana uses the Call # on the report to differentiate multiple claims and will deny such claims where the report is not attached. Mail hard copy claim to:

Aetna Better Health of Louisiana

P.O. Box 982962

El Paso, TX 79998-2962

Optional Procedure Code for Patient's Refusal to Participate in ET3 Model Interventions
For informational purposes, ambulance providers may include **G2022** on ambulance transportation claims to an ER that met ET3 model but the member refused TIP and transportation to alternative destination (TAD). ABHLA will pay such claims at $0.00.

Optional				
Procedure Code	**Description**	**When to use it**	**Where to use it**	**Fee**
G2022	Beneficiary refuses treatment in place services	Ambulance transport claims to an ER that met TIP or TAD criteria, but the patient refused.	CPT/HCPCS Code Field	$0.00

Treatment-in-Place Telehealth Claims:
Treatment-in-place telehealth services must be separately billed from treatment-in-place ambulance services.

Claims for allowable telehealth procedure codes must be billed with **the addition of G2021 procedure code**.

The G2021 code will be accepted, paid at $0.00 and used by Medicaid to identify treatment-in-place telehealth services. Please see details in the chart below.

As with all telehealth claims, providers must include POS identifier of "02" and modifier "95" with their claim to identify the claim as a telehealth service. Providers must follow CPT guidance relative to the definition of a new patient versus an established patient.

Procedure Code	**Modifier**	**Place of Service**	**Description**	**When to use it**	**Where to Use It**	**Fee**
G2021	95	02	TIP telehealth service	When providing TIP telehealth services	CPT/HCPCS Code Field; Must be used when Providers bill claims for the telehealth service.	$0.00

Billing & Rendering Providers
The Billing Provider's NPI must be enrolled as a professional service billing provider with the entity to whom the claim will be submitted (fee-for-service Medicaid or the MCO).

The rendering provider's NPI must be reported on the claim for both the E/M telehealth procedure code and the G2021 procedure code[1] and must be enrolled with the entity to whom the claim will be submitted (fee-for-service Medicaid or the MCO). Valid rendering providers are licensed physicians, advanced practice registered nurses, and physician assistants. Rendering providers must be 'linked' to the billing provider.

Approved Telehealth Procedure Codes:

Category	Service	CPT Codes

[1] Rendering provider NPI is required when it is different than the billing provider, ASCX 12N/5010X222

Evaluation and Management, Office, or Other Outpatient Service	New Patient	99201[2] , 99202, 99203, 99204, 99205
	Established Patient	99211, 99212, 99213, 99214, 99215

Recap:
ABHLA will enact edits to match ambulance TIP claims to the corresponding TIP telehealth claims and telehealth TIP claims to either ambulance TIP or ambulance transport.

There should be:

- no telehealth TIP without a corresponding ambulance TIP or ambulance transport.
- no ambulance TIP without a corresponding telehealth TIP service.

Ambulance treatment in place encounters without a corresponding telehealth encounter will be denied.

Claims for multiple treatment in place and treatment in place and transport claims rendered on the same date of service for the same recipient, submitted without Pre-Hospital Care Summary Reports will be denied.

Claims for TIP without modifier "Y" in the emergency indicator field will be denied.

MCO Physician Directed Post Payment Review Guidelines
The treatment-in-place service consists of a treatment-in-place (TIP) ambulance service plus a treatment-in-place telehealth service. Each paid treatment-in-place ambulance service must have a corresponding paid treatment-in-place telehealth service and each paid treatment-in-place telehealth service must have a corresponding paid ambulance TIP service or paid corresponding emergent transport to a hospital facility.[3]

Allow 365 business days to elapse from the date of service of the first paid claim before initiating investigations.

Identification of Ambulance TIP Claims/Encounters:

Ambulance TIP procedure codes are identifiable by procedure codes A0427 or A0429 with W destination modifier is W.[4]

Ambulance TIP claims/encounters are restricted to those on the Physician-Directed Ambulance Treatment-in-Place Fee schedule: **www.lamedicaid.com/Provweb1/fee_schedules/PDA_TIP.pdf**

Identification of Telehealth TIP Claims/Encounters:

Telehealth TIP service claims/encounters are billed using E&M codes with place of service 02, modifier 95 and procedure code G2021. G2021 claim line identifies the claim as a telehealth treatment in place service. Telehealth procedure codes billed without G2021 should be excluded from the match.

Telehealth TIP payable procedure codes are restricted to those found in the Treatment-In-Place (TIP) Telehealth Services Fee Schedule: **www.lamedicaid.com/Provweb1/fee_schedules/TIP_Tellhealth.pdf**

[2] Procedure code 99201 deleted effective with DOS 01-01-2021
[3] If a patient being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both the treatment in place ambulance service and the transport to the emergency room. In that case, the ambulance provider shall bill only for the emergency department transport.
[4] Origin and destination codes used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one code to be reported in modifier field. The first position alpha code equals origin; the second position alpha code equals destination.

Section 6: Issue Resolution

Providers experiencing issues with claims related to transportation brokers, must first seek a resolution directly via the transportation broker rather than contacting ABHLA, third parties, or the Louisiana Department of Health (LDH).

Should you experience issues with ABHLA's transportation broker, One Call, please contact them directly to resolve transportation claims issues:

MediTrans

Contact	Phone	Email
Claims Escalation - Carolyn Banks	844-349-4326	Llewis@meditrans.com
Billing Department		Billing@meditrans.com

Claim Appeal

Claim appeals must be received from the provider within 180 calendar days of the Remittance Advice paid date or the original denial date. A determination will be made by the broker within 30 days of receipt. Use the contact information below to submit requests:

MediTrans:
By phone: 844-349-4326
By email: Billing@meditrans.com

Formal Complaints

The following resolution options are available for all issue types, including claims. Providers should use the following contact information for complaints and escalation of issues through ABHLA:

Escalation Type	Contact Information
Formal Complaint	By phone: **1-855-242-0802** By email: **LAProvider@aetna.com** By mail: Aetna Better Health of Louisiana 2400 Veterans Memorial Blvd. Suite 200 Kenner, LA 70062
Management Level Contact	Stella Joseph, Manager of Appeal and Grievance **LAAppealsandGrievances@aetna.com**
Executive Level Contact	Bridget Galatas, CEO **Bridget.Galatas@aetna.com**

Formal Complaints through LDH

In the event a provider is not satisfied with the resolution or does not receive a timely response from ABHLA, the provider can contact LDH directly using the following contact information:

Email: MedicaidTransportation@la.gov

NOTE: Include detailed information on all attempts to resolve the issue through ABHLA, as well as contact information (contact name, provider name, e-mail, and phone number) of ABHLA staff. This will allow LDH staff to follow up with any questions.

Independent Review

Providers may also use Independent Review in conjunction with the claim appeals options in this notification. This option is available for resolution of all claim disputes. The Independent Review process may be initiated after claim denial.

NOTE: Per House Bill No. 492 Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

- The Independent Review process was established by La-RS 46:460.81, et seq. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial.
- Independent Review is a two (2) step process which may be initiated by submitting an Independent Review Reconsideration Request Form to the MCO within 180 calendar days of the Remittance Advice paid, denial, or recoupment date. Request forms are available on MCO websites or at **http://ldh.la.gov/index.cfm/page/2982**.
- If a provider remains dissatisfied with the outcome of an Independent Review Reconsideration Request, the provider may submit an Independent Review Request Form to LDH within 60 calendar days of the MCO's decision. Request form available at the link below.
- Effective Jan. 1, 2018, there is a $750 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.
- SIU post-payment reviews are not considered claims denials or underpayment disputes; therefore, SIU findings are exempt from the Independent Review Process.
- Additional detailed information and copies of above referenced forms are available at: **http://ldh.la.gov/index.cfm/page/2982**