Policy

DEPARTMENT: Utilization Management	**POLICY #:** UM.048
TITLE: Non-Emergency Ambulance Transportation	**VERSION:** 2
REVIEW APPROVED BY: UM Committee	**REVIEW APPROVAL DATE:** 12/18/24, 12/12/25
	POLICY COMMITEE APPROVAL DATE: 1/12/26
RELATED DEPARTMENTS:	
DEPENDENCIES: N/A	

Table of Contents

Purpose

This policy outlines the medical necessity criteria for non-emergency medical transportation (NEMT) based on the Medicare Benefit Policy Manual Chapter 10- Ambulance Services. This policy specifically addresses NEMT ground transportation. Air ambulance services are subject to prior authorization and medical necessity determinations. Parameters for coverage are noted in the Medicare Policy Manual Chapter 10- Ambulance Services and will not be further defined in this policy.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
UM	Utilization Management
BLS	Basic Life Support
ALS	Advanced Life Support
CMS	Centers for Medicare and Medicaid Services
NEMT	Non-Emergency Medical Transportation

Policy

Longevity Health requires prior authorization for NEMT services for its beneficiaries. Coverage criteria for NEMT is outlined below. To be covered, ambulance services must be medically necessary and reasonable.

Necessity and Reasonableness

Per the Medicare Benefits Policy Manual, “Medical necessity 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, whether or not such other transportation is actually available, no payment may be made for ambulance services.”

To summarize, if a member can safely be transported via stretcher transportation, wheelchair transportation, or any other non-ambulance ground transportation without endangering the member’s health, the ambulance is not medically necessary. Medical necessity is not dependent

on the availability of alternative services. If the member does not meet medical necessity for an ambulance but the member has no readily available alternatives, medical necessity is still not met for the ambulance services.

Required Documentation

Based on the Medicare Benefit Policy Manual, the following clinical documentation elements are required to accompany a prior authorization request to support the medical necessity review.

1. Physician certification- a statement signed and dated by the beneficiary's attending physician which certifies that the medical necessity provisions of this policy are met.
    a. If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a non-physician certification statement must be obtained. Definitions of non-physicians are outlined in § 410.40 Coverage of ambulance services.

    Physician or non-physician certification does not necessarily prove or disprove whether the transport was medically necessary.

2. Clinical indication that the beneficiary is bed-confined before and after the ambulance trip. This is defined by the presence of all the below criteria:
    a. Beneficiary is unable to get up from bed without assistance
    b. Beneficiary is unable to ambulate
    c. Beneficiary is unable to sit in a chair or wheelchair

    Bed confinement does not necessarily prove or disprove whether the transport was medically necessary.

    The records must contain clinical assessment data, with objective findings such as:

    a. History of condition, and/or reason why beneficiary is unable to get up from bed without assistance
    b. Muscle strength scale assessment, trunk strength
    c. Physical mobility assessment with transfer ability inclusive or activities of daily living (ADLs)
    d. Any and all applicable clinical data supporting condition
    e. Clinical assessment data, with objective findings such as:
        - History of condition, and/or reason why beneficiary is unable to sit in a chair (including wheelchair)

- Muscle strength scale assessment, trunk strength
- Physical mobility assessment with transfer ability, ADLs
- Any and all applicable clinical data supporting condition

f. Clinical assessment data, with objective findings such as:

- History of condition, and/or reason why beneficiary is unable to ambulate
- Muscle strength scale assessment, trunk strength
- Physical mobility assessment with transfer ability, ADLs
- Any and all applicable clinical data supporting beneficiary condition

Blanket statements, addendums, and attestations, including letters of medical necessity will not stand alone and require the original documentation from the beneficiary's medical record as support.

Duration of Authorization

If the NEMT service utilizing an ambulance is a recurrent or repetitive, scheduled event, the prior authorization may cover services for the duration of treatment or for up to 3 months at a time (whichever comes first). This may be appropriate in situations such as dialysis, infusions, or others. The units approved during the prior authorization window will be based on the frequency of services (ex: dialysis three times per week would result in a 3 month authorization for 72 one way trips).

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
1.0	New	11/2024	Stefanie Caswell	New
2.0	N/A	12/12/2025	Stefanie Caswell	Annual Review, no changes