Clinical Policy: Transportation for Care Coordination

Reference Number:HI.CP.MP.505 Coding Implications
Last Review Date: 08/23 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description This policy describes the medical necessity requirements for transportation services.

Policy/Criteria

I. It is the policy of Ohana Health Plan that a transportation attendant is **medically necessary** when all of the following criteria are met:

A. Member is traveling:
   1. Inter-island
   2. Out of state

B. Written justification is submitted to include ALL of the following:
   1. When and why the attendant is required (e.g., time during travel for appointments and/or special needs)? Additional documentation may be required for more than one attendant, AND
   2. Expected roles, tasks, etc. that the Member cannot perform for themselves, or that the transportation service cannot perform for the Member, AND
   3. Qualifications of the attendant(s) such as a healthcare professional (e.g., Certified Nursing Assistant [CNA], Licensed Practical Nurse [LPN], Registered Nurse [RN], Medical Doctor [MD], etc.). For attendants that do not meet qualifications, what alternatives exist?

C. In addition to the conditions above, the attendant must meet one of the following criteria:
   1. The attendant is an adult accompanying a minor child;
   2. The attendant is needed to assist the Member with his/her special needs.
   3. Members with any of the following conditions may require an attendant:
      a. Sensory deficits (e.g., blindness/poor vision, deficits in hearing or receptive/expressive language disorder
      b. Behavioral Health diagnosis and condition that precludes normal function among the population
      c. Convalescence from surgical procedures
      d. General weakness (bed and chair bound)
      e. Protection from hazards (e.g., protection from smoking)
      f. Decubitus (skin sores) or other problems which prohibit sitting for a long period of time where assistance is needed
      g. Incontinence or lack of bowel control (catheterized)
      h. Assistance with going to the restroom
      i. Artificial stoma, colostomy or gastrostomy
      j. Need for human assistance for mobility, with or without aids (e.g., crutches, walkers, wheelchairs or limbs [splinted or in a cast])
      k. Poor function or in need of supervision (confused, disoriented, hostile, agitated or wanders off)
      l. Alzheimer's Disease (or some other mental impairment)

m. Poor command of the English language

II. It is the policy of Ohana Health Plan that a travel attendant is **not medically necessary** for the following indications:

A. An attendant for companionship or social reasons
B. Children accompanying an adult Member
C. More than one attendant except in extenuating circumstances where one attendant cannot fulfill the travel needs of the member.
D. Personal care items for Member and for attendant(s)

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.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS* Codes	Description
T2001	Attendant
T2001 (TK)	Attendant (additional)

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		12/15
Annual review, no changes		11/16
Annual review, no changes		09/17

Reviews, Revisions, and Approvals	Date	Approval Date
Annual review, no changes		09/18
Expanded policy		09/19
Expanded policy		11/19
Expanded policy		01/20
Transitioned policy to new state specific template and sent to market for ownership, Policy number changed from HS-314 to HI.CP.MP.505	9/2020	
Annual review, no changes	08/2023	

References

1. State of Hawaii Department of Human Services Med-QUEST Division. Hawaii Medicaid Provider Manual. ttps://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/provider-manuals/PMChp16.pdf. Published January 2011. Accessed October 24, 2019.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.