Centers for Medicare & Medicaid Services

Special Open Door Forum: Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model National Expansion

Moderator: Jill Darling

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2:00 pm ET

Coordinator: Good afternoon and thank you all for standing by. At this time, all participant lines are in a listen-only mode. After today's presentation, you will have the opportunity to ask questions, and you may do so over the phone by pressing star 1 at that time. Today's call is being recorded. If you have any objections, you may disconnect at this time. It is my pleasure to turn the call over to your host for today, Ms. Jill Darling. Thank you, ma'am. You may begin.

Jill Darling: Great. Thank you, (Holly). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to today's Special Open Door Forum "Repetitive Scheduled Non-Emergent Ambulance Transport Prior Authorization Model National Expansion.

Before we get into today's presentation, I have one brief announcement. This Special Open Door Forum is open to everyone, but if you are a member of the press, you may listen in, but please refrain from asking questions during the Q-and-A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And I would like to hand the presentation over to Desiree Haskins.

Desiree Haskins: Hello, everyone, and welcome to Repetitive Schedule Non-Emergent Ambulance Transport Prior Authorization Model National Expansion Open

Door Forum. My name is Desiree Haskins and I'm with CMS Center for Program Integrity, CPI.

On the line with me is Angela Gaston, who is also with CPI, and Janice Carter with Novitas, one of CMS Medicare Administrative Contractors.

The purpose of this Special Open Door Forum is to provide a live opportunity for ambulance suppliers, other Medicare providers, and interested parties to learn about the upcoming national expansion of Medicare Fee-for-Service Repetitive Scheduled Non-Emergent Ambulance Transport Prior Authorization Model, often known and abbreviated as RSNAT Prior Authorization Model.

Today, we will be presenting information on national expansion of the RSNAT Model, Prior Authorization Model- the prior authorization process. And then we will open the presentation for questions and answers.

The PowerPoint presentation slides can be found on http://go.cms.gov/taambulance. These slides can also be found in the Open Door Forum announcement.

To begin, Slide 2. The purpose of RSNAT Prior Authorization Model is to establish a prior authorization process for Repetitive Scheduled Non-Emergent Ambulance Transports to Medicare Fee-for-Service beneficiaries that are transported by independent ambulance suppliers who are participating in Medicare. RSNAT Prior Authorization Model also helps to reduce medically unnecessary expenditures, reduce improper payments, and protects the Medicare trust funds while maintaining or improving access and quality of care.

Slide 3, the history. The model began as a CMS Center for Medicare and Medicaid Innovation Center model under Section 1115A of the Social Security Act. The model allows, under Section 1115A, CMS to test a service by reducing program expenditures while preserving or enhancing quality of care. The model started in the states of New Jersey, Pennsylvania and South Carolina in the year 2014, and then in the states of Delaware, Maryland, North Carolina, Virginia, West Virginia, and the District of Columbia in 2016.

Slide 4. What was the criteria for RSNAT Prior Authorization to expand nationwide? One, the Secretary determined that the expansion is expected to reduce spending under applicable title without reducing the quality of care, or improve the quality of patient care without increasing spending.

Secondly, the chief - the CMS Chief Actuary certified that such an expansion will reduce or would not result in any increase in net program spending. And lastly, the Secretary determined that the expansion would not deny or limit the coverage of provision of benefits under the applicable title for applicable individuals.

Slide 5. Approval. The Secretary of Health and Human Services determined that the model met criteria for the national expansion. Next, national expansion was based on the Chief Actuary certifying the nationwide expansion of the model in the evaluation report conducted by Mathematica. Also, the Office of Management and Budget approved the information collection burden per the Paperwork Reduction Act. You can click on these links in the slide to review the Chief Actuary's certification and the report from Mathematica.

Slide 6. Announcement. CMS announced on September 22, 2020 that it would expand RSNAT Model nationwide. The model ended under Section 1115A

authority on December 1, 2020. And on December 2, 2020, the model transitioned under the authority of the Act via Section 515(b) of MACRA, without interruption, in states of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia.

Slide 7. On August 26, 2021, CMS announced implementation dates for all remaining states and territories by Federal Register Notice. On December 1, 2021, the RSNAT Prior Authorization Model will begin in the states of Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas in MAC jurisdiction JH.

No earlier than February 1, 2022, the RSNAT Prior Authorization Model will begin in states and territories of Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, North Mariana Islands, and Tennessee, in MAC jurisdictions JJ and JE.

No earlier than April 1, 2022, the RSNAT Prior Authorization Model will begin in the states and territories of Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands, in MAC jurisdictions JN, J6 and J5.

No earlier than June 1, 2022, the RSNAT Prior Authorization Model will begin in the states and territories of Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont, in MAC jurisdictions JK and J8.

And no earlier than August 1, 2022, the RSNAT Prior Authorization Model will begin in Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota,

Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming, in the MAC jurisdictions of JF and J15.

The railroad retirement for beneficiaries will be included in the model no earlier than August 1, 2022.

Now that we discussed the model and its history, what is prior authorization? Slide 8. Prior authorization is a process in which a request for provisional affirmation of coverage is submitted for review before a service is rendered to a beneficiary and before a claim is submitted for payment. Prior authorization helps to make sure that applicable coverage, payment and coding rules are met before services are rendered. Some insurance companies got certain Medicaid programs and the private sector already uses prior authorization.

Slide 9. Coverage and documentation requirements has not changed. The model does not create any new documentation requirements. It simply requires the information to be submitted earlier in the claims process.

Slide 10. Medical necessity. Medicare requirements and coverage of ambulance service can be found in CFR 42 sections 410.40 and 410.41, and the Medicare Benefit Policy Manual Pub 100-02 Chapter 10.

Medicare covers ambulance service when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated to the nearest appropriate facility. The beneficiary condition must require both the ambulance transportation itself and the level of service. The transport must be a Medicare covered service and a Medicare covered destination.

Slide 11. Medical necessity and non-emergent ambulance. Medicare's ambulance benefit for non-emergent transport is very limited and designed only for beneficiaries who are clinically unable to be transported by other means. It is appropriate if either the beneficiary is bed-confined and it is documented that the beneficiary's condition is that other methods of transportation are contraindicated, or the beneficiary's medical condition regardless of bed confinement is that the ambulance transportation is medically required.

Slide 12. What is bed confinement? For a beneficiary to be considered bed confinement, all of the following criteria must be met. The beneficiary is unable to get up from the bed without assistance. The beneficiary is unable to ambulate. And the beneficiary is unable to sit in a chair or wheelchair. Bed confinement is not the sole criterion and determinant of medical necessity non-emergent ambulance transportation. Rather, it is one factor that is considered a medical necessity determination.

Slide 13. Medicare may cover Repetitive Scheduled Non-Emergent Transportation by ambulance if all medical necessity requirements are met, as we had previously discussed on the previous slides. And the ambulance supplier before furnishing the service to the beneficiary obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met. The physician order must be dated no earlier than 60 days before the date of service is furnished.

Slide 14. In addition to medical necessity requirements, the service must meet all of the Medicare coverage and payment requirements. Requirements may be related to the origin and destination, the vehicle staff and billing and reporting. The service must also meet Medicare covered destinations.

Medicare covered destinations include hospitals, critical access hospitals, skilled nursing facilities, from a nurse from a SNF to the nearest supplier of medical necessity, services not available at the SNF where the beneficiary is a resident, and not in a covered Part A stay, including the return trip.

Other Medicare destinations include the beneficiary's home and dialysis facility for end-stage renal disease patients who require dialysis. Note, a physician's office is not a covered destination except under very limited circumstances.

Slide 15. Now that we discussed non-emergent ambulance transport, what is Repetitive Non-Emergent Ambulance Transportation? Repetitive Non-Emergent Transportation is medically necessary ambulance transportation that is furnished three or more times during a 10-day period, or at least once per week for at least three weeks. These repetitive transfer transports are often needed by beneficiaries who are receiving dialysis or cancer treatment.

Slide 16. Who is eligible for prior auth, eligibility? Who is eligible for prior auth? Who is included? All independent ambulance suppliers providing Part B Medicare covered services and billing on the CMS 1500 form and/or 837P electronic transaction.

Who is excluded? All hospital-based ambulance providers owned and/or operated by a hospital, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agency, hospice, and transport that's included in any Part A bundled payment. And also, ambulance supplies under review by the United Program Integrity contractor (UTIC) are excluded.

Slide 17. The following HCPCS codes are subject to prior authorization. HCPCS AO426, which is the advanced life support, ALS, non-emergent transport level one. HCPCS AO428, basic life support, BLS, non-emergency transport. The mileage code A0425 does not require prior authorization. It is paid only when either HCPCS AO426 or AO428 is covered, and should be billed on the same claim as the transport code.

Slide 18. Benefits of prior authorization. Prior authorization of ambulance suppliers and beneficiaries would know before the service whether Medicare will pay for service. Another benefit of the prior authorization model is that ambulance suppliers can address issues with claims prior to claim submission by unlimited opportunities to correct issues. Therefore, reduces denials and the need for appeals. Prior authorization also reduces time for payments as compared to prepayment reviews, and provides protection from most future audits.

Slide 19. Beneficiary impact. The beneficiary will receive a notification of the decision about their prior authorization request. What is not changing for the beneficiary? The Medicare service benefit, dual eligible coverage, private insurance coverage, the advanced beneficiary notice/ABN, policies and claim appeal rights.

This concludes my discussion as it relates to RSNAT Prior Authorization Model and its history, unchanged medical necessity requirements, what type of ambulance suppliers are eligible, and benefits of prior authorization. Thank you so much for your time and attendance.

Now, I will turn it over to Angela to talk about the prior authorization process.

Angela Gaston: Thank you, Desiree. My name is Angela Gaston and I also work in the Center for Program Integrity on the RSNAT Prior Authorization Model.

Starting on Slide 21, we're going to move into the prior authorization process and how you submit a request. Either the ambulance supplier or the beneficiary can submit the prior authorization request to their respective MAC. Though the beneficiary can technically submit the request, it is typically the ambulance supplier. The request can be mailed, faxed, submitted through the MAC provider portal or submitted through the Electronic Submission of Medical Documentation, the esMD system.

So, the first component of the prior authorization request is the basic information that is listed on Slide 22. So the request needs to first identify the beneficiary's information; the certifying physician's information; the ambulance supplier's information; the requester's name and telephone number so that the MAC will know who to contact if they have any questions; the procedure code; the submission date; the start of the 60-day period; the number of transports requested; the state where the ambulance is garaged; if it's an initial or resubmission request; and also indicate if the request is expedited and the reason why.

Submitters are encouraged to use their MAC's prior authorization request form. The use of the form is not required. And it does vary by MAC, so you want to make sure you're using the form from your MAC's website. Slide 23 has an example of Palmetto's request form. As you can see, all the elements listed on the previous slide are included here on this form, so it is quite helpful to use. And you can also find your MAC's mailing address and fax number listed on the form.

If you are in a state starting in December, Novitas has their form available on their website now. If you are in a state starting later in 2022, the forms are not available yet. But please check back with your MAC as it gets closer to your implementation date.

The second component of the prior authorization request is the medical documentation. This is listed on Slide 24 and includes the physician certification statement. Please note that assigned physician's order by itself doesn't demonstrate medical necessity. So, you also need documentation from the medical record. This needs to include a clear description of the patient's current condition supporting the need for the transport, dated prior to the date of transport. And this information must be from the patient's clinician and not from the ambulance supplier. Also included should be information on the origin and destination of the transport and any other relevant document as deemed necessary by the MAC.

Slide 25 describes the number of trips covered under a single prior authorization. You can request up to 40 round trips for up to a 60-day period per request. An affirmative decision can be for all or only part of the requested number of trips and days you requested, as supported by the medical documentation. If your patient needs additional trips or days, you can submit an additional prior authorization request.

We do have a special consideration for beneficiaries with chronic medical conditions that are deemed not likely to improve over time and directly impacts the need for the ambulance transport. The MAC may affirm up to 120 round-trip for up to a 180-day period for beneficiaries that meet this criteria. And please note that this is solely at MAC discretion to affirm an extended affirmation period. The medical records must clearly indicate that the condition is chronic, and the MACs must also establish a pattern through

previous prior authorization requests. You cannot request this extended affirmation period. The maximum number of trips that you can request remains at 40 round trips for up to a 60-day period. And if your patient does receive an extended affirmation period, please remember that the ambulance supplier is still responsible for maintaining a valid PCS at all times, which are only valid for 60 days.

So, once the MAC receives the request with the relevant documentation, they have 10 business days to render their decision for both initial and resubmitted requests. There are a couple of important definitions on Slide 27 that we touched on a few times already, and I want to make sure we clarify them.

An initial request is the first prior authorization request for any 60-day period. If your patient receives an affirmed prior authorization decision and needs additional transport for a new 60-day period, that would be another initial request because it's for a brand new period. A request is considered resubmitted only if the initial request was not affirmed and you submit another request with additional documentation for the same time period. And those resubmissions are unlimited. You can resubmit as many times as necessary.

We also have an expedited process available only when the standard timeframe jeopardizes the life or health of the beneficiary. But since this model is for non-emergent transport, these requests should be extremely rare.

Next, I'm going to turn it over to Janice Carter, the clinical supervisor from CMS MAC Novitas Solutions, to offer some additional tips on the documentation and a little insight on how the MACs conduct these reviews. Please note that there is not a corresponding slide for Janice's remarks.

So, welcome, Janice, and I'll turn it over to you.

Janice Carter: Thank you, Angela. I appreciate it. Hi, of course, I'm Janice Carter from Novitas Solutions. I am the Clinical Supervisor for the program for Non-Repetitive Ambulance Transports. Angela asked me to give you an overview of what we look for as a MAC.

Of course, the first thing we look for, has been said, is the Physician Certification Statement. And as they said, it must be dated at least 60 days prior to or on the start of this date of the trips requested on your request. It must be signed by the attending physician- an MD or a DO. It cannot be signed by a Nurse Practitioner or a Physician Assistant. So, we make sure that that's on the Physician Certification first.

We also look for origins and destinations, of course, to confirm that they are approved destinations through Medicare. And they can be on a separate document because I know it's hard to squeeze it on that form. So, we do accept it if it's listed on a separate document.

Trip reports usually are not considered prior authorization in the review as this is for prior authorization. So, if you send in a trip report, more than likely we're not even going to consider that in our determination. If the PCS indicates they are bed-confined or unable to get out of bed without assistance, unable to ambulate, or unable to sit in a wheelchair or a chair safely, we need more information to support that or the condition that supports the service.

Simply a statement on a PCS, like she said, needs to be supported with medical documentations. And we look for all kinds of medical documentation that can go with that. Physical therapy, occupational notes from nursing homes or from home care. We look for home care notes or assessments, office visit notes, that include not only the subjective data like the patient is

deconditioned or weak. We look for, okay, what - to what extent is that? So, we look for the objective data to go as well with the subjective data.

So, if the patient is unable to sit in a wheelchair, we need to know what conditions is such that the patient really is not safe to sit in a wheelchair. We have seen documentation where a patient can sit in a wheelchair. But what we need to know is what makes them not safe. Is it a cognitive disorder where they can't follow commands or they're at a risk to get up and fall while they are in transport?

So, we need to know that. We need to know upper body strength or extremities. Are they not able to hold themselves up without support in a wheelchair? This kind of information is very helpful.

So, what we want to know is, okay, we know that the patient is weak, we just need to know to what extent the patient is weak. The whys that go with it.

Such as, if they can sit safely and they are able to ambulate but they have to use oxygen, in and of itself, oxygen is not a reason for this type of transport. We need to know is the constant monitoring of their O2 saturation required, and the patient can't adjust or regulate their own oxygen levels. Or they have fluctuating glucose monitoring that needs to be constantly monitored to make sure their sugars are within normal limits. Those kinds of things that require not only the need for the transport but also for the need for the personnel.

So, we look for several different information to go along with subjective observations. So, objective data along with a subjective review of the patient's condition all go to painting a clear picture of what that patient looks like and really requires the documentation.

That's it for me. Do you have any questions, Angela?

Angela Gaston: Thank you, Janice, so much. And we will - Janice will be on to help with questions at the end.

And if you are following along with the PowerPoint, we are back on Slide 28. So, after the MAC conducts the review, they will send the decision letter to both the ambulance supplier and the beneficiary. All decision letters include a unique tracking number, a UTN, that must be submitted on the claim. We will talk more about the UTN in just a bit. Decision letters with an affirm decision will include the number of transports and the time period that was affirmed. Decision letters with a non-affirmed prior authorization decision will include a detailed explanation on why the request was not affirmed.

Moving to Slide 29, an affirm decision means that a future claim likely meets Medicare's coverage, coding and payment requirements. The claim is linked to that affirmed decision via that UTN, and it will be paid as long as all other Medicare requirements are met.

There are a couple of things to note regarding an affirmed decision. First, it does not follow the beneficiary. An ambulance supplier cannot use a UTN that was requested by another ambulance supplier. So, if multiple ambulance suppliers are providing transport to a beneficiary during the same time period, the prior authorization decision will only cover the ambulance supplier indicated in the request.

And number two, only one ambulance supplier can request prior authorization per beneficiary per time period. If the initial ambulance supplier cannot complete the prior authorized transport, the initial supplier should contact the MAC to cancel their prior authorization, and then the subsequent ambulance

supplier is then able to submit their own prior authorization request for that beneficiary.

If a prior authorization request is not affirmed, there are two options as listed on Slide 30. You can correct the prior authorization request and resubmit with appropriate documentation, as described in the non-affirmed decision letter. You can resubmit an unlimited number - unlimited number of times. But since a prior authorization decision is not a claim determination, it cannot be appealed.

Or the ambulance supplier can decide to render the transports and submit the claim with a non-affirmed UTN. The claim will be denied, but at that point you have a claim determination and all appeal rights become available. And if applicable, you can also submit that claim to a secondary insurance.

Slide 31 describes how to submit a claim after obtaining the UTN. There are instructions here for both an electronic 837 professional claim and for a paper 1500 claim form. This information can also be found in the operational guide on our website. And please note that the UTN assigned to the transport code should not be included on the mileage code. But the mileage code should be billed on the same claim as the transport code.

Slide 32 outlines the prior authorization request timeframes. Ideally, prior authorization should be requested prior to rendering transport. But claims for the first three round trips are permitted to be submitted without prior authorization to allow time to submit the prior authorization request and obtain approval.

If additional time is needed to obtain an affirm decision beyond the first three round trips, the ambulance supplier may continue to render the transports.

Affirmed prior authorization decisions can retroactively apply to transports already rendered if the documentation supports the medical necessity at the time of transport. Please keep in mind, if you are submitting a prior authorization request after rendering the transport, the PCS is still required to be signed prior to rendering any transports. And if you are using this approach, claims after the third round trip should be held until the UTN has been received, so that it can be submitted on the claim.

So, what happens if you don't use the prior authorization process? You can still render transports, but the MAC will stop the claim for prepayment review. This means that the MAC will make a claim determination before claim payment using the standard Medicare prepayment review process. This includes the MAC sending an additional request letter to the ambulance supplier, the ambulance supplier submitting the documentation within 45 days, and then the MAC reviewing the submitted documentation within 30 days. Again, we strongly encourage you to use the prior authorization process.

Slide 34 summarizes all the scenarios that we've been discussing so far. In scenario one, the prior authorization request is submitted, it's affirmed, the ambulance supplier could render the service and submit the claim with the UTN, and the MAC will pay that claim as long as, of course, our usual disclaimer, all other requirements are met.

In scenario two, the prior authorization request is submitted, but if it's not affirmed, this is where the ambulance supplier has two choices. They can render the service and submit the claim with the UTN. The MAC will deny the claim but then all appeal rights are available. Or the ambulance supplier can correct the error and resubmit the request, and the MAC will then review the resubmitted request.

Or, scenario three, you can skip prior authorization. The ambulance supplier can render the service and submit the claim as usual, but the MAC will stop the claim for prepayment review and request documentation from the ambulance supplier.

Slide 35 has resources for more information. Our website link can be found here. In particular, I'd like to point you to the Operational Guide and the Frequently Asked Questions that are found on our website. Both have a lot of really helpful information. You can email us questions to ambulancepa@cms.hhs.gov.

You can also contact your MAC. If you are in a state that is starting in December, Novitas has their website up and have already started MAC-specific provider education webinars. If you are in a state starting later in 2022, the MACs are still working on those websites, so please keep an eye out for that, as well as trainings in your MAC jurisdiction as it gets closer to your implementation date.

So that concludes our slide presentation. We'd like to open it up now to questions. We also have with us today our division director Amy Cinquegrani, and a few representatives from two of our MACs, Novitas Solutions and Palmetto GBA to help us with some questions.

Coordinator: Thank you. If you would like to ask a question, please ensure your phone is not muted. Press star 1, and when prompted, clearly record your first and last name so I may introduce you. To withdraw your request, press star 2. Again, to ask a question, press star 1. It may take a few moments for questions to come in. Please stand by.

Our first question comes from Kathy Lester. You may go ahead.

Kathy Lester: Hi. This is a question for the MACs, and I'm Kathy Lester, I work with the American Ambulance Association, and very excited to see the rollout of the prior auth. I know it's something we all worked on for a long time.

But you mentioned that oxygen alone is not going to be viewed as a reason for transport. And this question kind of applies to oxygen, but other areas as well, where you may have state law that prohibits transporting a patient who has a particular device or requirement like oxygen any way other than ambulance. And I'm just wondering how you take into account those specific state laws that kind of bind the ambulance provider to, you know, be told they have to do this. And so, want to make sure folks understand how that is taken to account in your assessment.

Janice Carter: Hi, this is Janice Carter. Your keyword is state requirement, that is at a local level, so you're looking at more like a Medicaid type service requirement for state?

Kathy Lester: No. Yes, this would be at the state or the local level where the transportation is prohibited in other ways. So, it wouldn't be just limited to the Medicaid program. It would also apply to transports involving Medicare.

It would be part of the regulation, the oversight of ambulances generally at that state level. So, think about it kind of like the way, you know, physicians have your scope of what they're allowed to do or not do. It's kind of similar to that, but these are restrictions on how certain types of patients are transported.

Coordinator: And our next question is from (Amanda Wetzel). You may go ahead.

(Amanda Wetzel): Hi there. I was just wondering if I'm understanding correctly that patients that are in their Medicare Part A stay, they would be exempt from this and - prior authorization, and instead would follow - continue to follow the normal consolidated billing guidelines like for Medicare Part A patients that are needing transport multiple times a week for dialysis, things like that?

Angela Gaston: That's correct. If it is part of a bundled Part A stay, actually anything that comes in on a Part A claim, it would be excluded.

(Amanda Wetzel): Okay, when you say bundled, do you mean not bundled to the SNF, bundled - like Medicare will make that additional payment then?

Angela Gaston: So, it is bundled or not bundled? I'm sorry.

(Amanda Wetzel): Well, yes, some people say bundled doesn't mean that the SNF pays for it, and some people say bundled doesn't mean that Medicare pays for it. So, I wanted to clarify that, like patients that are in their Medicare Part A stay that go out for dialysis by ambulance multiple times a week, so long as they meet medical - they meet the medical necessity for the transport, Medicare usually pays the transport provider directly for those. So that would continue and we wouldn't need to worry about prior authorization in that setting, right?

Angela Gaston: Okay. If they are being transported by an independent ambulance supplier and the independent ambulance supplier is billing Medicare separately through Part B, then the independent ambulance supplier would be responsible for obtaining the prior authorization. But if it's bundled in a Part A payment, or if it's coming in on a Part A claim form, then it would be excluded.

(Amanda Wetzel): Okay. So - okay. I'm not -I'm still not clear, I apologize. I assume that when the ambulance providers send in the claim, it's on a 1500 claim form for their

dialysis transport. So, they would meet prior authorization then even if the patient is in a Medicare Part A stay, because I believe that the ambulance providers bill Part B. The skilled nursing facility doesn't pay for those when it's for dialysis and multiple days a week. Medicare pays for those directly to the ambulance provider, so those would need prior authorization then.

Angela Gaston: Yes, it sounds like it.

(Amanda Wetzel): Okay. I will follow up with any other questions through email. Thank you.

Angela Gaston: You're welcome.

Coordinator: Your next question is from (Jerry Hurley). You may go ahead.

(Jerry Hurley): Yes, ma'am. We have kind of an outlier question. But from time to time we are called upon basically, and let me back up and use, for instance, a dialysis patient. And let's say that this dialysis patient moving forward is prior auth, but with another service. And in the course of day-to-day business due to mutual aids and more patient utilization, we may be called upon to service that patient independently- maybe one of those repetitive trips.

As the independent supplier for that repetitive trip, although we are not prior authorized, how would we submit for reimbursement for that single trip? Because there would already be a prior authorization number in place for that parameter of time. So, is that going to be something that has to be addressed? Is there something normally that we do?

We are in Kentucky at the present time. And like I said, with an adjacent service, from time to time we're called upon as a professional courtesy to service another patient. But how would we - with them having the prior

authorization number at that point, how would we in turn be offered reimbursement for that isolated case? Maybe once in their 40 - in their round trips, this might happen three individual trips, not even a round trip, maybe a take-home or a take-in.

Angela Gaston: Sure. Yes, you can still render that transport and you can submit your claim as normal. But the MAC will stop it for the prepayment review and request the documentation. So, you don't need to go through prior authorization. The MACs will stop it once you submit the claim and get that documentation from you.

(Jerry Hurley): So, you're saying it will be denied basically on the first level and then we'll have to appeal for it.

Angela Gaston: Oh, no, no, it won't be denied. It just gets stopped prior to payment. And it's just like a standard prepayment review, if you've ever gone through that process in the past. So, the MACs just stop it and you have to send in documentation. The MACs will review it. If everything is good, then it gets paid.

(Jerry Hurley): Okay, thank you.

Angela Gaston: Yes.

Coordinator: Your next question is from (Jillian Guthrie Stoneberger). You may go ahead.

(Jillian Guthrie Stoneberger): Hi. Yes. I was wondering if there was any resource online that clarifies what Medicare considers restraint, if the gurney strap meets the definition of restraint, or is it something else specifically.

Angela Gaston: Janice or Lendi, is that a question you could handle?

(Janice Carter): Well, gurney straps (unintelligible) for safety measures for all patients, correct? So that would not be considered a restraint. You would have to give us more detail that the patient needs constant monitoring for fear of flight, a risk of cognitive ability to follow instructions, more detail as to why you need to be there to keep them safe. Does that make more sense or answer your question?

(Jillian Guthrie Stoneberger): Yes. And the risk of cognitive ability to follow instructions, so, for patients with dementia or altered mental status. I thought that that didn't constitute medical necessity either. We would have had to have something in addition like restraints because they were altered or unable to follow directions.

(Janice Carter): Well, you're looking at somebody who is unable to follow your commands, who's always trying to get up, who may fall forward and break a hip. We're also looking for somebody who's a risk or a danger to self and others. They're combative or you can't constrain them, you know, as far as keeping them safe. They would get up, and if they were in a back of a wheelchair, then they might try to get out of that wheelchair and open the door while in motion, those kind of things. We're looking at risk.

If they sit there docile, they're cooperative, they follow what you're saying, even though they might not comprehend it, no, that in of itself would not constitute a safety concern. So, you have to be very careful with your cognitive assessment.

(Jillian Guthrie Stoneberger): Okay. Thank you so much, I appreciate it.

Coordinator: And our next question is from (Amber Robin). You may go ahead.

(Amber Robin): Yes. We are hospital-owned and operated, just because I'm getting clarification that we are excluded?

Angela Gaston: Yes, that is correct. You are excluded.

Coordinator: And our next question is from (Alexis Canigan). You may go ahead.

(Alexis Canigan): Will there be a period of time where the website where we're able to submit these prior authorization requests prior to it actually being the law, yet to do so, so that we can test the system and make sure that everything is going smoothly?

Angela Gaston: Yes. Let me pull up the slide. On Slide 7 were all the start dates for each group of states. And two weeks prior to that, you'll be able to start submitting requests.

(Alexis Canigan): All right, thank you.

Coordinator: And our next question…

Jill Darling: (Holly), I'm sorry to interrupt. Just I received an email from Kathleen Lester. I think she's in the queue. Could you bring her up?

Coordinator: That was the next person I was just going to introduce.

Jill Darling: Oh, perfect. Okay.

Kathy Lester: That was perfect timing. Thank you, guys. I just don't - I think I got cut off. I don't think the question about when state law requires patients to go by

ambulance and how that would be taken account in the prior authorization review was answered. I think we skipped onto another questioner.

But, you know, this is something that's obviously easy to share because it can be submitted, you know, with the documentation that there's a state law that mandates this. And I just wanted to know what ambulance services are supposed to do in that situation.

Angela Gaston: Kathy, this is Angela Gaston. You know, we have some representatives on from a couple of our MACs, but I'm not sure if that state and local law is any of their jurisdictions. So, we may need to take that one back and investigate and get back to you.

Kathy Lester: That is fair. And if you guys would like an example of it, I can also send it your way. But thank you for looking into it.

Angela Gaston: Right. Thank you.

Coordinator: And our next question is from (Patty Pearl). You may go ahead.

(Patty Pearl): Hi, good afternoon. Okay, so my first is on our patients that are in SNFs (unintelligible) their PCP because of (unintelligible) these patients, do we submit the (unintelligible) since the patient no longer (unintelligible)?

Janice Carter: Hi, this is Janice from Novitas. I am very sorry, I did not hear your question as it was breaking up really bad. Can we try it again please?

Coordinator: And, Patty, if you're still on the line, if you could ask your question again.

(Patty Pearl): Hello?

Coordinator: Yes, go ahead.

(Patty Pearl): Oh, okay. Sorry, it's because I have some difficulties right now. So, my question is, we have patients, dialysis patients, that are in nursing homes. They no longer see their PCP. They see the doctor that their nursing home has. And he comes maybe once or twice a month to see the patients. Do we submit the paperwork with his signature and the paperwork that they have there in the nursing home since we don't have - the patient no longer sees their previous PCP doctor?

Janice Carter: The attending physician at the nursing home can submit the supporting documentation as well as sign the PCS for that patient, yes.

(Patty Pearl): Okay. So, we would need to get medical records from the PCP, the previous PCP.

Janice Carter: Well, we will accept medical records from the nursing facility that he is at. We will accept their physical therapy notes or occupational notes, anything that will help paint a picture of the patient's current condition. You can reach out to their past PCP if you want. But I would stick to where they're currently located and see if you can get some documentations there.

(Patty Pearl): Okay. But in the - to submit the paperwork, whoever signs the prior authorization would be the nursing home doctor, since he's the one - he's the main one…

Janice Carter: Yes. If he's attending and he's the - yes. I don't mean to talk over you, I apologize.

(Patty Pearl): I'm sorry.

Janice Carter: Yes. If he's the one attending to the physician - the patient at the time, yes, he can sign the PCS.

(Patty Pearl): Okay. So, he would use, since he doesn't have his own, like, office, it'll - it would be okay for us to use the nursing home address as the address for the doctor, because that's where he goes and he sees the patient.

Janice Carter: Yes.

(Patty Pearl): Okay.

Janice Carter: As appropriate.

(Patty Pearl): All right. Thank you.

Coordinator: And our next question is from (Roxana Parks). You may go ahead.

(Roxana Parks): I was trying to get the - where the PowerPoint is located at, where I can go to find that. It was whenever she said it, it was too fast to write down.

Angela Gaston: If you have the announcement to the open door forum agenda, there is a link there. If you don't have that, it's http://go.cms.gov/PAAmbulance.

(Roxana Parks): Okay. And then the next question was, what website do we go to get the pre-authorizations?

Angela Gaston: To get the form?

(Roxana Parks): Yes.

Angela Gaston: Yes. Each individual MAC will have a website, so you'll need to go to your MAC's website. Most of them - only Novitas, they're starting December 1st in those states. Their website is up and running and you can get the form there, if you're in one of those states. If you're in a state that's starting later in 2022, those websites aren't up yet, but they will be prior to your implementation date.

(Roxana Parks): Okay. Thank you.

Coordinator: Your next question is from Beth Brown. You may go ahead.

Beth Brown: Yes. (Unintelligible) we service a very small community in Manchester, Tennessee. And their nursing homes do not have buses and the public transportation does not run highly enough to (unintelligible) transport. If the patient has Medicare and Medicaid and the trip is not affirmed with authorization, then can we still submit it to Medicaid if we have the authorization from them?

Woman: Yes. If they are dual eligible, yes, you can reach out to Medicaid.

Beth Brown: Thank you so much.

Coordinator: And our next question is from (Kris Palmer). You may go ahead.

(Kris Palmer): Hi. I was just wondering why when requesting a UTN, Medicare or the MAC constantly denies our request, when all of the paperwork is clearly documented that the patient does require a stretcher transport.

Angela Gaston: Hi. This is Angela Gaston. Since this is a nationwide call, it's hard to get into specifics for specific prior authorization requests. But you can reach out to your MAC and they can hold individual educational calls and you can ask very specific questions to specific prior authorization requests.

(Kris Palmer): Okay. And then my next question is, I don't know if you guys can answer it, but after you get the UTN, after we received the UTN, we get Medicare over-payment letters requesting that they want their money back, even though I have a UTN and the patient is going to the hospital for chemotherapy. Do you know why I would be getting something like that when this is not part of SNF's consolidated billing?

Angela Gaston: This is another one that may be a little too specific to get into the details. But I don't know, does anybody from Novitas or Palmetto have any thoughts to that one?

Janice Carter: Angela, this is Janice from Novitas. My thought might be that this is a provisional affirmation. We would have to look at the individual claims and see if it's hitting another edit or audit that is stopping them from payment, or if we paid them, it hit another edit or audit that's asking for overpayment. We would have to look at this.

(Kris Palmer): Yes. The letter states that it's part of consolidated billing, but it's not. The patient goes for chemotherapy, which is not provided through the SNF, obviously.

Janice Carter: I would go back to my individual MAC contractor with that and see if they can do an internal review for you. That would be better.

(Kris Palmer): Okay.

Janice Carter: To see if they can figure out what really happened to your claim.

(Kris Palmer): Okay. All right, thank you. Again, no answers.

Coordinator: Our next question is from (Diana Allen). You may go ahead.

(Diana Allen): Thank you. I was wanting a little clarity, somebody had mentioned not sending run reports then, and I just wanted confirmation that you were referring to not wanting them for the specific requests that we were making. A lot of times, several of us are dual agencies that run both 911 and IFT. So, sometimes we're going to be the first on scene and then later we're taking my patient in other instances down the road.

So, we're going to be showing you why they're going to be going by us later. And I don't want to send run reports asking for prior auth only to have it denied because somebody sees a trip report.

Janice Carter: This is Janice. We're not going to deny because you just - you sent in a trip report. A trip report in and of itself will not support the service as repetitive. So, we really need those supporting documentation that would go with it. If you send it, we'll glance at it. But in and of itself, it will not make or break a case as far as if that's the only thing you send in for us to review, it probably will not get affirmed.

So, we still encourage you to send in the supporting documentation based on what was on the PCS, signed by the physician.

(Diana Allen): Right, understood. I just didn't want somebody to come across a run report and then be like, "Oh nope, they don't understand, this is a trip report. Nope, hard stop, we're done." Thank you.

Janice Carter: No. We won't do that. We'll look…

(Diana Allen): All right. Thank you.

Janice Carter: Uh-huh.

Coordinator: Our next question is from (Shelly Johnston). You may go ahead.

(Shelly Johnston): Hi. Can you elaborate a little bit more on the excluded list? My ambulance is owned by the hospital. So, if we have a repetitive patient, we do not need an auth?

Angela Gaston: Hi. Yes, that's correct. Basically, it comes down to if you are billing on a Part A form, is excluded. And so that's the - hospital-based ambulance providers that bill on the Part A form.

(Shelly Johnston): Okay, perfect. Thank you.

Coordinator: And before we go to the next caller, again, if you would like to ask a question, please unmute your phone, press star 1, and record your first and last name clearly when prompted.

Our next question is from (Patty Pearl). You may go ahead.

(Patty Pearl): Hi. Okay. My next question is, when we submit the first six, I understand that those are going to be paid. And then on the seventh trip that the patient has,

that's when it's going to be stopped and it's not going to be processed or paid until the authorization is obtained. Correct?

Angela Gaston: So, right, starting with that seventh one-way trip, if you don't have prior authorization, you can still submit it. It won't get automatically denied, it just gets stopped for prepayment review and the MAC is going to request documentation and then review the documentation.

(Patty Pearl): Okay. So, once that documentation is reviewed, then it'll start from that seventh trip onward, correct? Or will it start from the prior ones?

Angela Gaston: Can you repeat it please for me?

(Patty Pearl): So, if we submit the paperwork for - those trips, for that seventh trip, we submit the paperwork, and it gets approved. Then it'll start with that seventh trip or will it retro to the first six?

Angela Gaston: Okay. So, in this scenario, you're going through the prior authorization process, so now you've got an affirmed UTN.

(Patty Pearl): Uh-huh.

Angela Gaston: Okay. If you've already submitted those first six round trips, that's fine, those will pay. If you haven't submitted them, you'll need to put the UTN on there or it will get rejected back and the system will say you have a UTN, you need to include it on the claim. If you've already submitted, that's fine, it will pay. But if you haven't submitted them yet and then you do get an affirmed UTN, you need to include it on the claims for the first six one-way trips.

(Patty Pearl): Okay, so the seventh one will be paid once we get the UTN.

Angela Gaston: Uh-huh.

Man: I guess the question she's trying to ask is, if we're working, trying to get the UTN number and it takes us over 30 days to get the UTN number, those seventh claims are going to be denied. Once it does get approved, will you retro back to the seventh one with that UTN number and pay that back?

Angela Gaston: Okay, so a claim will never get denied solely because you don't have prior authorization. So, if you submitted those claims, they're going to get stopped for prepayment review, is what will happen. If you held onto those claims until you got that UTN number, then you can submit them with your UTN and they'll get paid.

Man: Okay.

(Patty Pearl): Okay. So, the authorization will be, you know, backdated for that seventh run. Because that was…

Angela Gaston: Yes, as long as the documentation - yes, as long as the documentation supports the trips that you've already rendered, yes, it will get backdated.

(Patty Pearl): Okay. Thank you.

Coordinator: And our next question is from (Jacklyn Hennegy). You may go ahead.

(Jacklyn Hennegy): Yes, this is (Jacklyn Hennegy). I have a question about the PCSs. It's very hard to get a PCS from the physicians already for these dialysis patients, how to get a hold of all the supporting medical records and the documents of physical therapy, home care, I mean, I have to do that for VA and I can't even

get the hospital to give me records. How do I get records from a doctor's office that they're not my records? All I have is a run report.

Lendi Watkins: Hey, this is Lendi Watkins at Palmetto. From a clinical standpoint, anytime that these patients are being transported, this is documentation that is not a new requirement. We expect that at any given point in time we could request this documentation for review, if we sent an ADR for the transport in any normal circumstance. We do encourage providers, ambulance suppliers to work very closely with not only the dialysis centers or the doctor's offices, sometimes the hospitals, to get this documentation and get it into their hands.

We have encouraged that relationship a lot of times with the nephrologist which sees the patients at dialysis. They do a comprehensive report once a month that they're required to do. That documentation is extremely helpful for dialysis patients, we found. But we do expect that whatever the PCS indicates is backed up with medical documentation within that time period, so that we can tell all of the clinical picture of the patients.

Anthony: Hey, this is Anthony from Novitas. I just wanted to add too that CMS do have a physician practitioner letter on their website. You can download that PDF letter and take it to the physician or the hospital where you're trying to get the documentation or PCS from.

And there is a sentence in there that states, and I'll read it real quick. "As the ordering physician/practitioner, you are required to supply the ambulance supplier or beneficiary the physician certification statement, as well as any other documentation that supports medical necessity for the Repetitive Scheduled Non-Emergent Ambulance Transports." So that may be very handy for you too as well.

(Jacklyn Hennegy): Where is that at?

Anthony: This is on the CMS website. So, if you go to CMS.gov and type in "Prior Authorization," you should see a Prior Authorization Initiative link. Once you get there, just click on the Ambulance- Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport. And if you scroll to the very bottom, to the download section, there's a Physician/Practitioner Letter.

(Jacklyn Hennegy): Okay. Thank you, that would be very helpful.

Anthony: No problem. Thank you for your question.

Coordinator: Our next question is from Tiffany Powell. You may go ahead.

Tiffany Powell: Hi, everyone. This is Tiffany Powell. My question is simple. A lot of this information is basically what we are already audited on. So, I'm wondering, does a prior authorization basically replace being audited in the future?

Angela Gaston: Hi, this is Angela Gaston. Yes, so the prior authorization request, it's not changing any documentation requirements. It's the same things that you've always been required to maintain. And I believe on one of the slides, on the benefits of prior authorization, we did talk about that. It does provide protection for most future audits.

There are, you know, we have our unified program integrity contractors that are looking for things such as fraud. We also have our comprehensive error rate testing contractor. They review a random sample of claims for the purpose of estimating the Medicare improper payment rate. And that is simply a random sample that we don't have any control over. So, absent of that or any

indication of fraud, that you will provide protection against future audits if you go through prior authorization.

Tiffany Powell: Thank you.

Coordinator: Our next question is from (Amy Wilkes). You may go ahead.

(Amy Wilkes): Someone actually already answered my question. I was looking for some sort of training materials to give the providers, explaining to them that they do have to provide this information in a timely manner. So, thank you.

Coordinator: Our next question is from (Renalyn Munoz). You may go ahead.

(Renalyn Munoz): Hi, good afternoon, everybody. I was - my question basically stems from clinicals and from the actual physician that can sign a PCS form. Is the nephrologist medical records and clinical notes and PCS form, is that acceptable documentation for the prior approval process?

Can you hear me? Oh, okay. I wasn't sure if you could hear me. Okay.

Janice Carter: Takes me a second to get the unmute button. We accept any documentations from dialysis center, from the PCS, from your - the nephrologist. We'll take a look at it and provide you with a determination or feedback on the documentation letter. If it's not quite clear enough what is constituting the transport, we will certainly indicate that in our decision letter and be glad to go over that with you as well.

((Crosstalk))

Janice Carter: Sorry.

(Renalyn Munoz): No, I'm sorry, I didn't know - I thought you were done already.

So, the other question that we do have is, I know that there's ambulance companies that do home assessments. They actually go and visit the patients and they fill out a complete documentation, status of the patient, before they start doing any type of repetitive patient prior to the approval process. I know that this is coming directly from the ambulance supplier and I know that you're saying that you don't want documentation from the supplier like the trip before you need other documentation. But is that acceptable as well along with everything else, as long as it's an independent review of the patient?

Janice Carter: Typically, the documentation would come from the facilities, nursing home assessment provided by a nursing home health person, individual physician's offices. Yes, we would prefer or require to have those kinds of documentations as well. If you want to submit one with it, I would strongly suggest you send in other documentation as well.

(Renalyn Munoz): Okay. And I just wanted to kind of voice the opinion as well, is that physicians and their medical officers and trying to get their notes and having them, regardless of what rule is out there, exists out there, that they're supposed to give us this information, it's very difficult to get it in a timely fashion. So, I think that's something to take back and note because it could hinder, you know, having to transport an actual patient that may need the service.

Janice Carter: Again, like, we do prefer to have those documentation, and if you take the letter that is - that Anthony mentioned earlier, to that physician, that might help facilitate you obtaining those medical documentations that you need.

(Renalyn Munoz): Okay. We will give it a shot, but it's always very difficult to get them to respond in a timely fashion. Thank you.

Janice Carter: Thank you.

Shannon: Hello, this is Shannon with Palmetto GBA. Just along with that, I would like to add that we do also share this as education in our other events for physicians and physician's offices and for different facilities. So, please be aware that in addition to that letter that CMS crafted, that the MACs also reach out to the physician community to help you with that.

(Renalyn Munoz): Okay, I appreciate that. Because it's very challenging to begin with to go through the whole authorization process and to coordinate all these repetitive patient transports, and it's much of a burden on the ambulance companies. It's a lot - it's a huge undertaking, honestly, for the reimbursement that we do get for these patients.

So, I think that any help that CMS or the MACs can provide in educating the physicians and the requesting facilities and the ones that are requesting this information, or the transport, that they're very aware of what medical necessity really means and that, you know, where we have some backup here. Because it's going to be a very trying time for these repetitive transports.

Coordinator: And our next question is from (Sarah Lindsay). You may go ahead.

(Sarah Lindsay): Hi. I have patients that transport three times a week to dialysis and then also at times go five times a week for hyperbaric therapy. Now, sometimes they're going from their Skilled Nursing Facility to dialysis, and then from the dialysis to the wound care, and then from the wound care back to the Skilled Nursing Facility. For those patients, would we need to have a separate prior

authorization for the dialysis and the wound care, or would it be all inclusive in one authorization?

Lendi Watkins: Hey, this is Lendi from Palmetto. Typically, with those, we see that the normal transport amount is enough to accommodate those, all of those transports at one time. However, if you need more than you were initially affirmed for, we ask that you submit documentation for additional trips and explain the necessary extra or overage. And typically, we can work with that with the documentation. But most cases, we - manage with the 80 transports.

(Sarah Lindsay): Okay.

Coordinator: And again, if you would like to ask a question, please unmute your phone, press star 1 and record your first and last name when prompted. Our next question is from Alexis Cunningham. You may go ahead.

Alexis Cunningham: I have two real quick questions, one touches on what the woman previous to me just asked. She - you said that so many transports should cover those extra runs. But are they going to be not denied but held back because the destination was different than what the request for prior authorization was, like the initial prior auth was to dialysis and now it's going to a different location for wound care, does that prior authorization number only correspond to those specific modifiers and addresses?

Woman: No, we do not. Not for the modifiers. As long as it is - it's defined as a Repetitive Scheduled Transport, it would fall under that UTN for those dates of service.

Alexis Cunningham: Okay. And then my other question goes back to a gentleman that asked several questions before. We get kind of six free transports before we need

this. If another ambulance company has provided those six transports, does that six start for the patient or does it start for the ambulance company that is billing for these transports? Like, if another ambulance company has already transported this patient six times in the last 10 days, are we going to get blindsided by him needing prior auth now that we didn't know he was going to need for our seventh trip, even though it's really our first?

Janice Carter: Hi, this is Janice with Novitas. I will say that once the patient has been established of - or receiving repetitive transport, you will need to get - you will need to get a prior authorization for those transports. The system will count transports only once for that patient.

Alexis Cunningham: Okay. So, regardless of what ambulance company provided those initial transports, once you flagged him as being repetitive, we could need it on our very first transport.

Janice Carter: That's correct.

Alexis Cunningham: Okay, thank you.

Coordinator: And our next question is from (Roxana Parks). You may go ahead.

(Roxana Parks): Yes. Just a quick question here for (unintelligible). The prior authorization is just for the repetitive transport, not for a simple transport from hospital to nursing home, a one-time thing, or a hospital to residence one-time thing.

Angela Gaston: Yes, that's correct. It would have to be a repetitive transport to qualify.

(Roxana Parks): Okay. Thank you. All right, thank you.

Coordinator: And our next question is from Beth Brown. You may go ahead.

Beth Brown: Going back to the lady that just asked the question about (unintelligible) authorization on (a first) transport they would provide. If a patient goes to the hospital and then comes to our area for transportation, how will we know if they already have an authorization on file? Our area (get patients) from several counties away and the nursing homes that we (unintelligible) always know their history prior to the hospitals.

Woman (Janice Carter): Are you talking about a one-way trip?

Beth Brown: No, for repeating dialysis, say, they were on dialysis before they went to the hospital, another ambulance service has authorization. They come to our area after the discharge from the hospital. How are we going to know if they've already had their first six trips and then we - they require it on our first one, but if they already have an authorization altogether?

Shannon: This is Shannon with Palmetto GBA. Typically, in that situation, if you know that they've already been receiving dialysis, then there's some transport taking place. You know, like you said, the SNF may have some information or they may not.

Probably the first thing to do would be to ask the patient, if they are able to speak to that, or the SNF, or whoever they were seeing prior to the SNF. But you can also - you can also submit for a prior auth and we would look at it and see as well. But the first thing would be to try to find out what you could in speaking with everyone else who's worked with the patient.

Janice Carter: This is Janice. Novitas agrees. If you want to go ahead and submit for a prior auth, if they have an existing prior auth already on file with the UTN, you will

get a determination letter that will say it would be not affirmed as there is already - well, it will be dismissed as there already is an active UTN for that beneficiary.

Beth Brown: Thank you.

Coordinator: And I show no additional questions at this time. But again, if you would like to ask a question, please unmute your phone, press star 1, and record your first and last name clearly when prompted so I may introduce you. Again, that's star 1 to ask a question.

And we have another question from Alexis Cunningham. You may go ahead.

Alexis Cunningham: Okay. You just said that if we submit a prior authorization, we could get a letter saying no, because they already have that number for another provider. But we have patients who switch nursing homes all the time. What do we do to get that number switched to us?

Janice Carter: Well, we first suggest that you reach out to the current transporting service and see if they will call us to expire their existing UTN. If you're finding that you're having difficulties, you can contact us and we can try to reach out as well to the provider who has the UTN, and ask them if they're still transporting the patient, and if they are not, would they dismiss their UTN or release it. And then we would notify you that it's okay to resubmit for a prior auth. But we do ask that you try to contact the beneficiary or the ambulance who are transporting to acquire the UTN.

Alexis Cunningham: Okay. So, we have to ask our competitors to release the right to transport a patient to us?

Janice Carter: We ask that you try to reach out to the beneficiary and see if they can get the ambulance transport to expire their UTN or if you can contact them and ask them to expire their UTN prior to contacting us, that usually is beneficiary and - beneficial. And usually, you find that they're pretty cooperative.

We haven't had too much lately where another - in fact, we've had ambulance services call us and expire voluntarily the UTNs saying they're no longer transporting the patient, which is what we would prefer. If an ambulance service is no longer transporting, we would prefer them giving us a call and expiring that existing UTN.

Alexis Cunningham: Okay. And if they're unwilling to do that and the patient is unable to do that, a lot of these nursing home patients are not able to complete a task like that, does Medicare have the final say on who a UTN is assigned to?

Janice Carter: Actually, no. What we do is we, if you do not have cooperation, you can give us a call on our contact center (unintelligible). MACs have the ability for you to reach out to us and see if we can ask, reach out to the existing ambulance service. Or you can go ahead and provide the service and go through prepay, and then submit the UTN for the next round, for the prior authorization.

Alexis Cunningham: Okay.

Jill Darling: Hi, (Holly). It's Jill. If we do have more questions, we have time for one more please.

Coordinator: Okay. And our next question is from (Christina Brandt). You may go ahead.

(Christina Brandt): Hi. Yes. So, I did have a question, and it was pertaining to that one that you all kind of answered before, about the medical records, the (HMPs) that

we get from the PCPs. We're a private ambulance transport, so we transport a lot of patients to dialysis and wound care.

A lot of our patients don't get a chance to see their primary PCPs. They're just - and these are ones that are not going from the nursing home to dialysis, but going from their residence to dialysis. They don't really get a chance to see their primary doctors except for maybe once a month. They should be going more than that per their social worker.

But my question is, is if they're continuously going to go see their nephrologist for dialysis, are those medical notes going to be okay to support and get a prior authorization? Because we tried to do that before and they've just gotten shot down- because we bill out for North Carolina and they have always wanted to have a prior auth for repetitive transports. So, is that something that's going to actually be covered?

Janice Carter: Okay. So, the question is, if you get documentation from the nephrologist's office or the dialysis services, or wound care note. It still needs to point to what is on the PCS.

So, if you say the patient is bed-confined at some place on any of those notes, it needs to tell us what they mean by bed-confined. If they are unable to sit safely in a wheelchair, get up without assistance, unable to ambulate, or they require it because they have special handling, (wound -VAC), that it's been a situation where it's not safe for them to manipulate that (wound-VAC), those kinds of documentations need to clearly express why they need the service that the Physician Service Certification statement is on.

So, if you get the physician certification from the nephrologist, the documentation from the nephrologist note should support what he stated on that PCS.

(Christina Brandt): Okay. So as long as I have all that information and it doesn't contradict each other, then the PA should be approved then.

Janice Carter: Without seeing your documentation, if it all supports each other and it can clearly demonstrate that the patient requires the transport, yes.

(Christina Brandt): Right. Okay. All right. That's just the - that's the only question I needed to know.

Jill Darling: All right. Well, thank you, everyone, for joining today's Special Open Door Forum. We are a minute over the call end time. But if you did have a question and you were left in the queue, please email ambulancepa@cms.hhs.gov. We appreciate your time, and have a wonderful day, everyone.

Woman (Janice Carter): Thank you.

Coordinator: And this concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please stand by.

END