Centers for Medicare & Medicaid Services

Questions and Answers from Special Open Door Forum:

Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model National Expansion

October 28, 2021

1. 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.
    a. 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?
        i. 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 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.
2. 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 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?
    a. 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.
        i. When you say bundled, do you mean not bundled to the SNF, bundled - like Medicare will make that additional payment then?
            1. So, it is bundled or not bundled?
                a. 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?

i. 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.
    1. 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.
        a. Yes, it sounds like it.

3. 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.
    a. 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.
        i. So, you're saying it will be denied basically on the first level and then we'll have to appeal for it.
            1. 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.

4. 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.
    a. Gurney straps 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?
        i. 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.
            1. 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 kinds 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.
5. We are hospital-owned and operated, just because I'm getting clarification that we are excluded?
    a. Yes, that is correct. You are excluded.
6. 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?
    a. 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.
7. 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. 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.
    a. The medical documentation submitted by the ambulance supplier with the prior authorization request needs to clearly state why the patient cannot self-administer/regulate their oxygen and why the patient requires a licensed EMS personnel to administer that oxygen. (*Recently updated.*)
8. 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? He no longer sees their previous PCP doctor?

a. The attending physician at the nursing home can submit the supporting documentation as well as sign the PCS for that patient, yes.
    i. Okay. So, we would need to get medical records from the PCP, the previous PCP?
        1. 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.
            a. 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?
                i. Yes. If he's attending, yes. If he's the one attending to the physician - the patient at the time, yes, he can sign the PCS.

9. 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.
    a. 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.
        i. What website do we go to get the pre-authorizations?
            1. To get the form?
                a. Yes.
                    i. Yes. Each individual MAC will have a website, so you'll need to go to your MAC's website. If you're located in one of the states starting December 1st, Novitas Solutions, the MAC for jurisdiction H, has their website up with the form available. If you're located in a state that's starting later in 2022, those websites aren't up yet, but they will be prior to your implementation date. (*Recently updated.*)
10. 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?
    a. Yes. If they are dual eligible, yes, you can reach out to Medicaid.
11. 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?
    a. 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.

i. 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?
    1. 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.
        a. 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.
            i. 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. To see if they can figure out what really happened to your claim.

12. 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.
    a. We're not going to deny because 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.
13. 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?
    a. 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.
14. 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?
    a. 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.

i. 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?

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

a. So, the seventh one will be paid once we get the UTN.

15. 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.

a. 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. I just wanted to add too that CMS does 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. 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.

16. Does a prior authorization basically replace being audited in the future?
    a. Prior authorization is not changing any documentation requirements. It's the same documentation 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. 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, prior authorization will provide protection against most future audits. (*Recently updated.)*
17. 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?
    a. We accept any documentations from dialysis center, from the PCS, from 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.
        i. 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?
            1. 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.
                a. 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 having to transport an actual patient that may need the service.
                    i. 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.

1. Okay. We will give it a shot, but it's always very difficult to get them to respond in a timely fashion.
    a. 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.
        i. 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 huge undertaking, honestly, for the reimbursement that we do get for these patients. 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.

18. I have patients that transport three times a week to dialysis and then also at times go five times a week for hyperbaric therapy. 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?

    a. 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.
19. 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?
    a. No, we do not. Not for the modifiers. As long as it's defined as a Repetitive Scheduled Transport, it would fall under that UTN for those dates of service.
        i. 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?
            1. I will say that once the patient has been established of - or receiving repetitive transport, you will need to get a prior authorization for those transports. The system will count transports only once for that patient.
                a. 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.
                    i. Correct.
20. 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.
    a. Yes, that's correct. It would have to be a repetitive transport to qualify.

21. 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.
    a. Are you talking about a one-way trip?
        i. 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?
            1. Typically, in that situation, if you know that they've already been receiving dialysis, then there's some transport taking place. 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 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. 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.

22. 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?
    a. 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.
        i. So, we have to ask our competitors to release the right to transport a patient to us?
            1. 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.
                a. 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?
                    i. 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.

1. Okay.

23. 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. 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. 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?
    a. 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.
        i. Okay. So as long as I have all that information and it doesn't contradict each other, then the PA should be approved then.
            1. Without seeing your documentation, if it all supports each other and it can clearly demonstrate that the patient requires the transport, yes.