CENTERS FOR MEDICARE & MEDICAID SERVICES

Special Open Door Forum:
Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport
Tuesday, August 5, 2014
1:30 p.m. ET
Moderator: Jill Darling

Operator: Good afternoon. My name is (Michelle) and I will be your conference facilitator today. At this time, I would like to welcome everyone to Centers for Medicare and Medicaid Services Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Ms. Jill Darling. Please go ahead.

Jill Darling: Thank you, (Michelle). Good morning and good afternoon everyone and welcome to today's Special Open Door Forum. This call is scheduled until 2:30 so we will keep it to the hour. We'll go ahead and begin and I will hand this call over to Connie Leonard.

Connie Leonard: Thank you, Jill. Hello, everyone and thank you for taking time out of your busy schedule to attend our call today. This is the first of several calls on prior authorization of repetitive non-emergent ambulance transport.

And we are very excited to be joining to this new endeavor. This is the second endeavor for CMS in this prior authorization. Some of you may have

heard about the successful demonstration going on right now of power mobility devices.

And we've been very encouraged by not only the successful demonstration but also the feedback that we've received from our supplier community. And we think that the same type of feedback – the positive feedback is going to come out of this model.

And so we want to begin slowly and we want to get your feedback and get your insight into how we can do this smoothly. We're going to give our presentation and then have a Q&A session and we may not be able to answer all your questions but we certainly take them back and provide an answer– if need be at the next call or via e-mail – through the e-mail box.

Go ahead and get answers to you and with that I'll turn it over to Jennifer McMullen to start the presentation.

Jennifer McMullen: Hello everyone. We want to let you know that the slides for the presentation are up on our model Web site. The link is actually in the Open Door forum announcement. It can be found at http://go.cms.gov/PAAmbulance.
The purpose of this model is to establish a three year prior authorization process for repetitive scheduled non-emergent ambulance transport, and to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payment to protect the Medicare trust fund by granting provisional affirmation for a service prior to submission of the claim.

Prior authorization is a process through 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 ensure that applicable coverage, payment and coding rules are met before services are rendered. Some insurance companies such as Tricare, certain Medicaid programs, and the private sector already use prior authorization to ensure proper payment before the services rendered.

A repetitive ambulance service is defined as 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.

Repetitive ambulance services are often needed by beneficiaries receiving dialysis, wound or cancer treatment.

So who and what are affected? So the who; are ambulance providers that are not institutionally based, that provide Part B Medicare covered ambulance services and are enrolled as an independent ambulance provider.

So the what; is repetitive scheduled non-emergent ambulance transport claims billed on a CMS 1500 form or HIPAA compliant electronic equivalent.

The model will begin in the fall of 2014 in the states of New Jersey, Pennsylvania, and South Carolina and location is based on where the ambulance is garaged.

The medical necessity requirements for medical coverage of ambulance services are set forth in 42 CFR §410.40(d). Medicare covers ambulance services including air ambulance, fixed wing and rotary wings when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.

The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Medicare coverage policies, documentation requirements, and timeframes for transport will not be change.

The model does not create any new documentation requirements. It simply requires the information to be submitted earlier in the claims process. Current requirements can be found on the MACs' Web sites.

Also unchanged are that the MACs will be conducting reviews, all the Advanced Beneficiary Notice policies, and claim appeal rights.

What has changed? The provider will know before the service is rendered whether Medicare will pay for the service.

Upon request, the beneficiary will be notified before the service is rendered whether Medicare will pay for the service.

As of July 31st 2014, the prior authorization request is to identify the beneficiary's name, Medicare number, and date of birth; the physician's name, NPI, and address; the provider's name, NPI, and address, the procedure codes, and the submission date.

The request also needs to include the Physician's Certification Statement, number of transports requested, documentation from the medical record to support the medical necessity of repetitive scheduled non-emergent ambulance transport, information on origin and destination of the transport, and any other relevant document as deemed necessary by the contractor to process the prior authorization.

The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips or 80 one-way trips per prior authorization request in a 60-day period.

A provisional affirmative prior authorization decision may affirm less than 40 round trips or affirm a request that seeks to provide a specified number of transports (40 round trips or less) in less than a 60-day period.

An affirmative decision can be for all or part of the requested number of trips. Transports exceeding 40 round trips or 80 one way trips in a 60-day period require an additional prior authorization request.

I'll now turn it over to Angela to talk about the prior authorization request submission process.

Angela Gaston: Thank you, Jennifer. The provider or the beneficiary may submit the prior authorization request. It can be mailed, faxed or submitted through the esMD system. Please check your MAC's Web site for the mailing address and fax number.

For the initial request, the MAC will make every effort to review the request and postmark the decision letter within 10 business days. For subsequent requests and these are requests that were initially non-affirmed and are now being resubmitted with additional documentation. The MAC will make every effort to review these requests and postmark the decision letters within 20 business days. For emergent circumstances, the MAC will make reasonable efforts to communicate a decision within two business days of receipt of all applicable Medicare required documentation.

Decision letters are mailed to the providers and to the beneficiary, if requested. Decision letters that do not affirm the prior authorization request will provide a detail written explanation outlining which specific policy requirement was not met.

When a prior authorization request is submitted but not affirmed, a submitter can either resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request or provide the service and submit the claim. The claim will be denied but at that point all appeal rights are available.

For non-affirmed prior authorization requests, unlimited resubmissions are allowed. These requests are not appealable, however, for denied claims all appeal rights apply.

So what happens if you don't use the prior authorization process? The answer is pre-payment review. If a provider has not requested prior authorization before the fourth round trip in a 30-day period, the claims will be stopped for prepayment review. The MAC will send an Additional Request letter and waits 45 days for a response. Then the MAC will review the submitted documentation within 30 days. Without a prior authorization decision, the

provider and the beneficiary will not know whether Medicare will pay for the service and the provider or the beneficiary may be financially liable.

CMS strongly encourages providers to use the Medicare prior authorization process.

So to summarize the few different scenarios that can occur. The first scenario, the prior authorization request is submitted. The MAC's decision is affirmed; the provider can then render the service and submit the claim.
The MAC will pay the claim as long as all other requirements are met.
Scenario two, the prior authorization request is submitted but the MAC's decision is non-affirmed. The provider can either submit the claim, the MAC will then deny that claim and at that point all appeal rights are available or the provider can fix and resubmit the prior authorization request. Scenario three, the prior authorization request is not submitted therefore, there's no MAC decision, the provider can choose to render the service, submit the claim and then the MAC will stop that claim for prepayment review.

As for the beneficiary impact, the service benefit is not changing and beneficiaries upon request will receive a notification of the decision about the prior authorization request.

The MACs have additional information on ambulance services. For New Jersey and Pennsylvania, you're in jurisdiction JL Novitas. South Carolina is in jurisdiction J11 Palmetto. You can also check on our Web site. We have Fact Sheets, frequently asked questions, and information on open door forums, including the slides for today's presentation. The address again is http://go.cms.gov/PAAmbulance.

So to quickly summarize, the model is to begin in the Fall 2014 and will last three years in the states of New Jersey, Pennsylvania, and South Carolina. The prior authorization request can be submitted by the provider or the beneficiary.

For more information you can check out our model Web site or you can e-mail the prior authorization team at AmbulancePA@cms.hhs.gov and now I'll hand it back to Connie Leonard for additional information.

Connie Leonard: Thank you, Angela. So before we open for Q&A, I want to go through some of the most common questions that we get in the e-mail box at least so far.

We often get asked about what are the benefits for using prior authorization. And as Angela pointed it out, there is no monetary penalty to not using prior authorization but there is certainly an impact to the supplier because if they choose to not use the prior authorization process that claim as Angela said will get stopped for prepayment review, every single claim. Every single claim for every single beneficiary. So what that means is the claim will come in, it will get stopped and then you will get a request to send in the documentation and then so that is time and then there is additional time once you send the documentation to give the Medicare administrative contractor time to review. So there is a significant delay in getting payment for that claim.

Going through the prior authorization process, there is a 10-day window to allow for the Medicare Administrative Contractor to make the decision but once it's approved or affirmed and that decision for that beneficiary is then affirmed, claims get through until there is a need for another prior authorization request.

And so there really is a benefit to suppliers using the prior authorization process, we believe one – this is a change and we do understand it's going to be a change in the supplier process and business model but we do believe that once they get in the habit of working with the MAC and submitting these requests then it would be very beneficial for their business.

Also very – just want to point out that the request does not need to be prior authorized until it gets to the fourth round trip. So if you get an order for non-emergent ambulance transport today or tomorrow, you can go ahead and provide and maybe the services needs to start tomorrow or in two or three days, you can submit the prior authorization request but still provide this first three round trip without having the need for the prior authorization.

It's once it gets to that fourth one that the system and the Medicare Administrative Contractor will stop it, requiring the prepay review and requiring the prior authorization request.

We are often asked about emergent circumstances too. We allow the – there'll be a process for emergent circumstances but because as I just said, the prior authorization is not needed until the fourth round trip and because this is only for scheduled non-emergent transport, we do not believe this is something that is necessarily going to be used on a regular basis.

The MAC or the Medicare Administrative Contractor is the one that you will work with to determine if a situation needs emergent and needs to be getting this in two business days. But as I've said, we expect it to be very rare because it's only for non-emergent transport and the prior authorization is not needed until that fourth round trip.

Also want to make sure everyone understands that with prior authorization at least in this model and the power mobility device model, that you as the supplier are allowed multiple submissions.

So if a particular prior authorization request is denied because documentation was missing, you can submit that same request again. There is not an appeal process for the denial of the prior authorization.

There is an appeal process for the denial of the claim, but for the actual denial of the prior authorization there is not an appeal process preserved because suppliers can submit – keep submitting a request again and again until all the necessary documentation is there is appropriate.

And lastly before we turn it over to Q&A, we are also being asked about the impact on Medicaid and beneficiaries that may be dual eligible, meaning that they can fall under Medicare and Medicaid.

The Medicare affirmation or denial has no impact on Medicaid, so if the Medicare claim and prior authorization is denied, suppliers, beneficiaries or their caregivers can still go through the appropriate state Medicaid agency and program to determine if those benefits can be get – can be found there.

We will be working with the three state Medicaid agencies to coordinate to make sure they are aware of the CMS Medicare program in the three states. We hope to have those setup before we begin but it will not impact our beneficiaries, you know rights or the ability of a beneficiary to get approval by Medicaid.

The Medicare denial is just that, a Medicare denial. With that, we are able to turn it over to Q&A if that is okay.

Operator: OK. As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions.

If you'll require any further follow up you may press star one again to join. Your first question comes from Kathy Lester from the American Ambulance. Your line is open.

Kathy Lester: Hi. Thanks. Thank you, Connie, for the presentation. It's very helpful. One other thing that we're wondering is whether the prior authorization will constitute medical necessity in terms of determining that for audit. So would an affirmative prior authorization determination mean that there would be no subsequent audits on those particular claims for that period in which the prior authorization was approved?

Connie Leonard: Thank you, Kathy. Yes. The prior authorization affirmation will constitute medical necessity for that period of time that the prior authorization is for. So it is for 80 round trips or 80 trips – 40 round trips then that claim will not be reviewed by the MAC or by recovery auditor.

Now, it is possible that claim prepay review occurs by the CERT contractor because they randomly select claims and it's certainly possible that it could be reviewed by another government entity but it will not be reviewed by anyone doing normal routine, medical review for CMS such as a MAC, recovery auditor, or specialty medical review contractor.

Kathy Lester: Thank you and just one follow up so the CERT reviewer will have the information regarding that prior authorization and the determination at the contractor level at that claim have or that set of claims had been approved to prior authorization?

Connie Leonard: Yes. That's absolutely correct. The prior authorization affirmation will be shared with the CERT contractor.

Kathy Lester: Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Ronnie Singh from Trinitas Hospital. Your line is open.

Ronnie Singh: Hi. This is Ronnie from Trinitas Hospital. Would you have – our ambulance are – this is hospital based and according to Slide number two it says institutionally based, is it institution or like private or am I going to be impacted by this also?

Connie Leonard: Ambulance transport from an inpatient facility is not included in this model.

Ronnie Singh: OK. Because I – most of my patients are coming from inpatient stay to – with the nursing home or going home or so I'm not – I don't have to get prior authorizations for any of my patients.

Connie Leonard: No, you do not and we certainly are working on updated frequently asked questions for our Web site and we will certainly clarify that in a recent – soon to be released FAQ.

Ronnie Singh: OK. But I do have one last thing – I do have like two patients that are round trips from our nursing home because we do have our own nursing home to dialysis and back would that fall under this prior authorization?

Connie Leonard: I do not believe so but we will clarify in the FAQ.

Ronnie Singh: OK. Thank you very much.

Connie Leonard: Thank you for the questions.

Operator: Your next question comes from Everitt Binns from Grandview Hospital. Your line is open.

Everitt Binns: My concern is that I just want to clarify again the question concerning institutions. Again, we have our ambulance – our service based ambulance by the hospital. My concern is that how does that – you're going to clarify that, how do we get that clarification to make sure that hospital based, institution based are exempt from this process?

Connie Leonard: Absolutely. We are going to put updated FAQs on our Web site and we will also schedule another Open Door forum where we will also make sure that we have that clarification but the Web site is going to be their best vehicle to get the update.

Everitt Binns: Would you repeat that Web site please.

Connie Leonard: You may check the Web site – yes one second.

Everitt Binns: Thank you.

Connie Leonard: It's http://go.cms.gov/PAAmbulance and because that's the short link PAA cases they have to be capitalized.

Everitt Binns: Thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from Bridget O'Brien from Crest Haven. Your line is open.

Bridget O'Brien: Yes. Thank you. I have a question in regards to we are a long term care facility and also we have facility. When we send people out for the ambulance is it our responsibility to get the approval or is it up to the ambulance company to get the approval?

Connie Leonard: It is up to the supplier – the ambulance supplier to get the prior authorization.

Bridget O'Brien: OK. Thank you very much.

Connie Leonard: Now the ambulance supplier will need all the information they need, so they still need the physician's certification statement, documentation to support the need for the transport but it is the supplier who makes the request for the prior authorization.

Operator: Your next question comes from Michael Massiwer from Washington. Your line is open.

Michael Massiwer: Hi, Connie. Thank you for doing this. My question is when you say working with the state Medicaid agencies what does that mean? Does it mean you'll be providing them information on there when people get a denial you'll be providing them with their alternative options in Medicaid or does that mean more than that?

Connie Leonard: No. What it actually it means that we are – we're informing the Medicaid state agencies of our pilot of our model and that we are doing this in the various states just to get their comments on all this in the event, you know, additional inquiry come in to the states.

So we will not be sharing denied claims or beneficiaries who were denied of the services under Medicare. It will be the industry and the supplier and the providers and their caregiver's responsibility to let them know that they are eligible for Medicaid and if they need to go through the Medicaid route.

Michael Massiwer: Thank you.

Connie Leonard: Thank you.

Operator: Again if anybody would like to ask a question, please press star one on your telephone keypad. Your next question comes from Rita Gassert from JFK Medical Center. Your line is open.

Rita Gassert: Thank you. My question was already asked just for being hospital based provider but I'd like to add to it, will there be a difference if you're using the

QM versus the QN modifier some transports are – because we're part of the township where there 911 system but others are private so will that modifier effect whether or not we are going to be subject to this. So I'll look on the Web site and see if there's an answer to that. Thank you.

Connie Leonard: Thank you. I do appreciate that. We will look into the modifier issue and certainly update to the Q&A on the Web site to see if there will be an impact. Thank you for the question.

Operator: Your next question comes from Shaquanda Michaels from Fucaerlan Healthcare. Your line is open.

Shaquanda Michaels: Hi. I was just wondering if you could confirm the effective date that this process will take place.

Connie Leonard: Right now, we are just saying that we will begin in the fall of 2014. We expect that we will be able to announce very soon on our Web site or our next Open Door forum. We expect that we will begin in one state, I've talked several times when to start slow and then certainly adding on a state but we should be able to release all of that information in the near future.

It will start before the end of the calendar year but it will – it's certainly not starting in the month of August and it'll be in the fall timeframe.

Shaquanda Michaels: OK. Thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from Valerie Mellon from Compliance Concepts. Your line is open.

Valerie Mellon: Hi. Thank you for the teleconference today. On slide 4 where you have definition of repetitive ambulance service, the repetitive service is a medically necessary ambulance transportation that is furnished three or more times during a 10-day period. Does that mean three or more round trips or three times being each leg of a transport?

Connie Leonard: It is three or more round trips. So it's six single trips for three or more round trips.

Valerie Mellon: Three or more round trips. Thank you very much for that clarification.

Operator: Your next question comes from Lisa Peck from Advanced Medical. Your line is open.

Lisa Peck: Please I wanted to make sure, I just want to ask, to submit the procedure code at their level of service changes, do you have to fill out a new authorization and go through the process?

Connie Leonard: We will clarify that but I do not believe so. The prior authorization for the transport in particular is by beneficiaries so we'll see reason they need the transport changes. Is that the question if there's a reason they need a transport changes?

Lisa Peck: No. If they would change from BLS to ALS for example?

Connie Leonard: Oh then yes we do believe that a new prior authorization will be required if that is the change and we will clarify that on a Q&A. Thank you.

Operator: Your next question comes from Roland Morris from Advanced Health Care. Your line is open.

Roland Morris: Hi. Could you clarify whether or not this scenario is applicable to a discharge from a hospital to skilled nursing for that discharge trip?

Connie Leonard: Yes. The discharge from a skilled nursing facility to somewhere else, that would not be included no.

Roland Morris: From an acute hospital to a SNF.

Connie Leonard: A one-time trip correct?

Roland Morris: Yes. It's a discharge trip to a SNF.

Connie Leonard: No, that would not be included. This is only for repetitive scheduled ambulance transport. It's something if you're going to dialysis this is probably the most common or– it was a treatment, than from a discharge from an acute hospital to SNF which would not be included in this.

Roland Morris: OK. Thank you.

Connie Leonard: Thank you.

Operator: Again if anybody would like to ask a question please press star one on your telephone keypad. Your next question comes from Judy Vang from Wittman Enterprises. Your line is open.

Judy Vang: Yes. I wanted to clarify again that you guys did this is for ambulance suppliers that we would need to be the one to get the prior authorization?

Connie Leonard: Yes. The supplier is the entity that will submit the prior authorization request, that is because the supplier that is receiving the payment.

Judy Vang: So how would they do that? Do they – when they arrived to the scene would they need to have all of that done before the transport or is that something that we obtained after the transport?

Connie Leonard: No. From a prior authorization perspective, it's a fourth round trip where you have to have this prior authorization approved. So when you first received the order for the non-emergent repetitive scheduled ambulance transport, if that order is not right there then shortly after used to be paying even in that case getting the physicians certification statement and all the other met claim information unless you have documentation.

So the same process will stay still, it's just you're going to make sure you have all of that in a timely manner where now I guess it's possible that you wait until you get the request from the MAC prepay review or postpay review to get all the information.

So it's very important for us to make sure that it is an accurate record for all the beneficiaries to be able to submit information in timely manner. Now, I

would lead you back to the local coverage determinations and the Medicare policies to determine if there are applicable timeframes, applicable dates that are required when the physician's certification statements required data for us, you know.

When the supplier is having the documentation but all of the necessary documentation does need to be with the supplier then for them to submit for the prior authorization request.

Judy Vang: So then that means is that the pickup facility will have to make sure that they cooperate with us in getting all of the sufficient documentation available?

Connie Leonard: You are correct. That is going to be very important for the facilities when you're taking out the patient for the physician have signed the certification statement. For the physician in making that order to be available to the supplier to ensure that they get all the information.

Judy Vang: Thank you.

Connie Leonard: We will also – I certainly hear that issue a lot with Medicare. All kinds of medical review can be hard in areas of Medicare payment where they're relying on physician documentation.

They're relying on getting their feedback, getting those records from the physician and so as much as possible we will reach out to the physician community, you know to have them call us and go to FAQ sheets and everything else to try to ensure that one they know about this, to ensure that they need to be timely in providing necessary information to the supplier.

Operator: Your next question comes from Becky Manderach from Clarion Medical. Your line is open.

Becky Manderach: Hi. How are you today?

Connie Leonard: Hello.

Becky Manderach: Hello. I was reviewing the FAQs of your web page and the question 19 - how many ambulance providers or suppliers can request the prior authorization for one beneficiary at one time period. And of course it's only one but how does the wrong one you know say, "I have to do that – I'm going to do the transport," but someone else is already requested it but they're not going to do it? How is it released?

Connie Leonard: That is a good question but I'm not sure. We certainly have considered the situation where someone is filling in and that's certainly foreseeable and a prior authorization is not needed if it's a one time – it's Thursday and you've needed perhaps someone else to take that.

But as far as the actual changing of the supplier, the ambulance transportation supplier is changing and they have to submit a new request which you have mentioned, how would that go about getting release in the system?

That's a great question. We'll get some more clarification on that for the next call for our FAQ. It's certainly one that I could see definitely happening and then the suppliers may change and I'm sure that we have addressed and it's not coming to my mind right now but we'll submit additional clarification out there for you.

Becky Manderach: No worries. Thank you very much.

Connie Leonard: Thank you for the question.

Operator: Your next question comes from Vitaliy Hryetsyk from Ace Medical Transport. Your line is open.

Vitaliy Hryetsyk: I have a quick question. Let's say we send the prior authorization form and it gets denied to not enough medical information on the submission. Will they go back after we resubmit it and if they disapprove will they still go back and cover the dates that we were asking for initially or will it be a forward process?

Connie Leonard: As for as the supplier is continuing to provide the transport while they're gathering the new documentation?

Vitaliy Hryetsyk: Yes.

Connie Leonard: I suspect suppliers would want to do then what could happen and I think our suggestion to the suppliers would be to hold your claims. Because when you put – why be in a situation is to where those plan I mean - it's because that is going to be more time consuming for you to get those claims paid.

So the problem would be that there is a documentation that you could relatively easily get from the physician or from – so make sure to have all the necessary information in your record to get the claims paid, so this is very easy for you to go ahead and resubmit.

And so for the short term situation that we don't think it would be a significant financial burden for the suppliers to hold their claims because the concern would be that if they are submitted, the claims will very well get denied and then it could be very time consuming for the supplier to get this fixed.

Once you say you have to go to appeal process but it's a very we'll see situation you know may escalate and it's taking much more time than it would had you – it is just how does it pay after you've got the affirmation.

Vitaliy Hryetsyk: OK. Thank you.

Operator: Your next question comes from Aisha Goode. Your line is open.

Aisha Goode: Yes. Will there be a listing of what documentation we should obtain to guarantee an affirmative answer?

Connie Leonard: We have begin to work with the Medicare Administrative Contractors and it is very possible that some of them may include additional information on their Web sites but we're not sure if they're going to or not but it's your best chance you know your best being call today is to really look at the local determination that the two MACs in Novitas and Palmetto put in place.

They both have the LCDs regarding the non-emergent ambulance transport. Both of the LCD's talked about documentation requirements necessary and

those are going to be the best place for suppliers to go to make sure they're submitting all the required information.

And those are available today on the Web site. It could certainly help those with issues trying to find out, to send them and e-mail them to our mailbox. We could certainly send you out the link to get – find on the CMS Web site that coverage database but it would be able to go and find different LCDs.

But those are going to be the best bets for suppliers to get more documentation requirements necessary is going to be those two LCDs.

Aisha Goode: OK. One more question. It says that we have 10 days well you guys have 10 days to either affirm it or deny it, for existing patients the effective date of this model versus the 10-day that you have to answer, will we have enough time to get our prior authorization request in so the cash flow doesn't stop?

Connie Leonard: Yes. We are considering – expect to happen and will be able to announce it soon definitely but before we begin, so when we set an effective date that we will allow period of time before hand where suppliers can submit the request to their MAC the existing transport that's ongoing today.

And you will be able to go ahead and submit those early to get those in the queue and to get this approved but it can begin as the effective date with the prior authorization request.

Aisha Goode: OK. That's going to be on the Web site?

Connie Leonard: Yes. We will make all those announcements on the Web site. The Web site is going to be a great vehicle for suppliers and other parties to go to have information; you know what's happening with the model.

And as we get closer to the effective date, obviously we'll have more this case of announcement where we'll be able to get the necessary info from the Web site.

Aisha Goode: Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Denise Jimenez from Empire Ambulance. Your line is open.

Denise Jimenez: Hi. I actually have two questions. One is about the emergent circumstances. What do you indicate when it is emergent circumstances?

Connie Leonard: We don't have any example of the emergent circumstance from an ambulance perspective. And the reason that we don't is because this is specifically for non-emergent repetitive scheduled ambulance transport.

So it is not for the typical ambulance transportation, you know we sometimes probably think of coming on ambulance suppliers, you know let me think of the ambulance. It's not that part; it's not that emergency room visit.

So for MAC perspective because it's not emergent, we don't really haven't been able to identify a situation where it might meet this emergent criteria, however, we want to allow the option because there could be some unique situation where this case of an emergent service could arrive.
And so we – as we talked with the MAC they may have, you know, certainly lots of experience doing the ambulance claims. These are reviews that they do today. We certainly we'll be talking to them about ideas that they might have it could be emergent.

And so it is in certain areas that if we can provide an example in the future we certainly will but I know, as I say, we have discussed and thought about this and we're certainly open to ideas that you guys may have.

But because we're not emergent and because the prior authorization is not required until that fourth round trip, we really haven't been able to think of something that may quantify as emergent.

Denise Jimenez: Maybe I can give an idea. Usually sometimes because that's our priority we usually have – that's our major patients – were dialysis patient. And sometimes the nursing homes call us because maybe a transportation company actually cancels on them and they would like us to give the service. Would

that be like an emergent circumstance where we need the prior authorization to transport the patient?

Connie Leonard: Well we never – it's again not necessary to have that prior authorization until the fourth round trip. Certainly you would be able to provide especially if they called today and they needed you tomorrow but then I'm sure it's probably what happens.

You would still be OK in providing that fourth round trip service and then submitting that type of request. It is possible especially if the prior authorization was approved already for that beneficiary, you know this process wouldn't even take 10 days.

I do know that in power mobility device demonstration the Medicare Administrative Contractors involved in the demonstration are not taking 10 days. I can't say that it'll happen in this model. Claims will may be different in this different type of claim but again because you were still be OK in providing that first round trip of care then I'm not sure if it meets the emergent criteria.

But we just simply send that with the MAC and again they'll be the ones to make any decision if something meets an emergent criteria or not and then determine if that might be a situation.

In this it's possible that the MAC may – or the MAC may say yes, you know that type of unique situation, you know, we would want to make that decision earlier but I'd like to talk to them and kind of see what their thoughts for giving and come up as an example that maybe we can give you.

As you know we had the same qualifier in the power mobility device demonstration and again this case of emergent circumstances it is not from a regular basis. Typically there is time frame for the industry to get this emergent need for the power mobility device. Again, we think the same is involved here because it simplifies the care, used to provide the transport but this was not used until the fourth round trip but there's still will be a time to go ahead and get the prior authorization request on the list.

Denise Jimenez: OK. And also I have another question since we have dialysis patients that we have in here constantly, these patients do make more than 40 trips or round trips during the 60-day period. Besides the prior authorization at that moment, do we have to get an additional one on top of that because that's what I'm trying – understanding?

Connie Leonard: Yes. So what happens for individuals that are on repetitive schedule ambulance transport for more than the 40 trips or 80 – 40 round trips, at that point in time that they get to 30 say or whatever is best in business you will need to submit another request.

So, you know say one transport for, you know, for long term or they're doing I can say more than the 40 and at the same period of time and they will need – you will need to submit an additional prior authorization request but once you get close to that 40 round trips.

Denise Jimenez: OK. So it doesn't have to be immediate, it will be after the 40. Before the 40 round trips or over.

Connie Leonard: Correct. Because they are not just only going – they have only have the ability to approve up to 40 round trips and so you know if you did it at 10, I would imagine they're not going to approve it, they're going to tell you to come back. I think it's closer but if you get at 30 I think that's I guess absolutely appropriate.

Denise Jimenez: OK.

Connie Leonard: And, you know this is a model so the – and so we have, you know used analysis to determine 40 round trips is what we wanted to do in a particular model and you know certainly may through evaluation, you know, determine that, you know, a less or more number, you know, that's a greater number if necessary, you know if this ever, you know through the evaluation and such.

But again it's one of the things that we're testing this model is one that does it work in this environment and two whether the appropriate parameters, you know, that would be in place into something would see on an national basis.

Denise Jimenez: OK. Thank you. I appreciate.

Connie Leonard: Thank you.

Operator: Your next question comes from John Bush from On Time Ambulance. Your line is open.

John Bush: Thank you. We're just wondering why you have decided to rule this out only to residence and not to facilities.

Connie Leonard: Again because it's a model, we are trying to, you know limit the population of the model because it is new and so anytime you know we are on a kind of a new initiative that we use to trying to try out some and you know we're thrilled. You know any potential issues. So that is why we are – at this time not including the facilities.

John Bush: But could you see if being something that you consider down the road?

Connie Leonard: I mean I can't answer that question today because I don't know how it's going to work but I do think that we have flexibility enough that as we chose we certainly could.

(John Bush): OK. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Kathleen Pittenger from Abelmed Transports. Your line is open.

Kathleen Pittenger: Referring to question 6 on the frequently asked questions, we're going to have an authorization tracking number, are the EDI services going to tell us the requirements so that we can make the appropriate coding changes to submit this electronically?

Connie Leonard: The prior authorization request can only be permitted three ways. It can come by mail, it can come by fax and it can come through esMD. It is currently not possible to submit a prior authorization request through the claim system.

Kathleen Pittenger: Well how – if we have a prior authorization and we have a tracking number once we have that authorization we can just submit the claim normally?

Connie Leonard: That is –

Margery Glover: Well for 23 but there will be an – there should be instructions from the MAC as to where they will be submitting it on.

Connie Leonard: So the MAC will be issuing other instructions as to what to do but my assistant here was telling me that once you get that unique tracking number you will put it in the claim and we believe that's block 23.

But stay tuned as I mentioned we are trying to refer with the MAC and so the MAC will be coming out, you know with more detailed information for suppliers so that you can submit that claim. And that unique tracking number is very important because that is what will bypass that claim to the payment and that's because it stops for prepayment review otherwise. And we need that on every claim for beneficiary.

Kathleen Pittenger: OK. Thank you.

Connie Leonard: (Inaudible). Thank you.

Operator: Your next question comes from Marcie Craig from Andres Medical. Your line is open.

Marcie Craig: Yes. You guys said that we can submit the request electronically but is there any way to get the decision electronically or is it going to be available by mail?

Connie Leonard: In the beginning, it will only be available by mail. Hopefully shortly after we begin, if you submit the request through esMD then you will be able to get a response through esMD and that is something that we currently do on the power mobility device documentation and has worked very well for the suppliers that are submitting through esMD. And we do hope that is going to

be something that will be available within the first three to six months of the model.

But in the very beginning, the only way to get this will be through the mail and it is possible that some of the MACs will make this available via their portal and will know more about that as we get into talking with the MAC more and leading up to start it.

Marcie Craig: Thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from Madeline Groark from Valley Hospital. Your line is open.

Madeline Groark: Hello. Can you hear me?

Connie Leonard: Yes.

Madeline Groark: My question is this I know that this is currently regarding repetitive non-emergency transport, is there any talk or discussion about doing this for the non-repetitive, non-emergency transport?

Connie Leonard: Not in this model. This model is only for repetitive scheduled non-emergent ambulance transport.

Madeline Groark: So there's no discussion in trying to implement this with the non-repetitive?

Connie Leonard: No.

Madeline Groark: OK.

Connie Leonard: Another time.

Madeline Groark: Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Shaquanda Michaels. Your line is open.

Shaquanda Michaels: I have an additional question on the authorization number in a way that it should be submitted over. You mentioned a moment ago that box 23 or the equivalent to that electronically is where the authorization number would go? Right now in that box is used for the point of pick-up zip code, so will that change as well?

Margery Glover: It would be starting with position 15 in item 23 so you would still report the zip code but the unique tracking number would be beginning position 15.

Shaquanda Michaels: OK. So will be the zip code followed by the authorization number.

Margery Glover: It should be, I guess.

Shaquanda Michaels: OK. Thank you.

Operator: Your next question comes from Aisha Goode from (Rescue Tech). Your line is open.

Aisha Goode: Hi. I just want to clarify or confirm that all dialysis patients that are in nursing home do not require prior auth?

Connie Leonard: That is something that we are going to confirm for an FAQ so look on our Web site for additional information about that, OK.

Aisha Goode: OK.

Operator: Your next question – oh I have no further questions in queue.

Connie Leonard: Well I would like to thank everyone today. We had some pretty questions so I appreciate everyone's interest and we'll have some work to do on our end. We will go back and we will update the FAQs on our Web site and we will start working on planning our next Open Door Forum and hopefully the next one we'll be able to announce more information about the start date and where we're going to begin.

If you have additional questions in the meantime, please go through the e-mail box that was mentioned earlier and I'll say one more time for everyone. It is

AmbulancePA@cms.hhs.gov and then that also it's available on our Web site. And with that, thank you everyone and stay tuned for our next Open Door Forum and updated FAQ document.

Operator: Thanks everyone. This concludes today's conference call. You may now disconnect.

END