

Repetitive Scheduled Non-Emergent Ambulance Transport Model Operational Guide
11/21/2014

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Purpose

The purpose of this Operational Guide is to interpret and clarify the prior authorization process for Medicare participating ambulance suppliers when rendering repetitive scheduled non-emergent transport services for Medicare beneficiaries. These guidelines are merely to assist and do not alter the documentation requirements that are set forth in 42 C.F.R. §410.40(d) and in applicable Local Coverage Determinations (LCDs) found at <http://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html>.

Chapter 1: Repetitive Scheduled Non-Emergent Ambulance Transport Benefit

For any service to be covered by Medicare it must:

- A. Be eligible for a defined Medicare benefit category,
- B. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- C. Meet all other applicable Medicare statutory and regulatory requirements.

The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 C.F.R. §410.40(d). Medicare covers ambulance services including air ambulance (fixed wing and rotary wing), when:

- A. Furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.
- B. 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.

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services can be found in 42 C.F.R. §§410.40, 410.41, and in the publication 100-02 Medicare Benefit Policy Manual, Chapter 10.

Non-emergent transportation by ambulance is appropriate if either:

- A. The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or,
- B. The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.¹

For a beneficiary to be considered bed-confined, the following criteria must be met:

- A. The beneficiary is unable to get up from bed without assistance.
- B. The beneficiary is unable to ambulate.
- C. The beneficiary is unable to sit in a chair or wheelchair.²

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished 3 or more times during a 10-day period; or at least once per week for at least 3 weeks.³ Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment.

¹ 42 CFR 410.40(d)(1).

² 42 CFR 410.40(d)(1).

³ Program Memorandum Intermediaries/Carriers, Transmittal AB-03-106.

Medicare may cover repetitive, scheduled, non-emergent transportation by ambulance if

- A. The medical necessity requirements described above are met, and
- B. 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 (see 42 C.F.R. §410.40(d)(1) and (2)).⁴

Further detail for the circumstance under which the transport will be covered by Medicare in each jurisdiction can be found through the following links:

- [Jurisdiction L LCD for Pennsylvania](#)
- [Jurisdiction L LCD for New Jersey](#)
- [Jurisdiction 11 for South Carolina](#)

⁴ Per 42 C.F.R. § 410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished.

Chapter 2: Model Overview

Who

- Ambulance suppliers that are not institutionally based,
- That provide Part B Medicare covered ambulance service, and
- Are enrolled as an independent ambulance supplier.
- Ambulance suppliers under review by a Zone Program Integrity Contractor (ZPIC) are **not** eligible to submit prior authorization requests.

The ambulance supplier or the beneficiary may submit the prior authorization (PA) request.

What

- Repetitive scheduled non-emergent ambulance transport claims not included in a covered Part A stay and
- Billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction.

Where

- The prior authorization model will impact the states of:
 - New Jersey,
 - Pennsylvania, and
 - South Carolina.

Location is based on the location where the ambulance is garaged.

When

- Ambulance suppliers and beneficiaries are encouraged to utilize the prior authorization process for all repetitive scheduled non-emergent ambulance transports beginning on:
 - **December 1, 2014** for repetitive scheduled non-emergent ambulance transports scheduled to occur on or after **December 15, 2014**.
 - All repetitive scheduled non-emergent ambulance transports with a date of service on or after **December 15, 2014** must have completed the prior authorization process or the claims will be stopped for prepayment review.
 - The model will continue for repetitive scheduled non-emergent ambulance transports for three years.

Additional Information

- Submitting a prior authorization request is voluntary.
- If an ambulance supplier in a model state does not submit a prior authorization request, the claims for the repetitive scheduled non-emergent ambulance transports will be subject to pre-payment review.

- Ambulance suppliers or beneficiaries should place the unique tracking number on claims submitted for these transports.

Chapter 3: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to the Prior Authorization Model

Ambulance HCPCS Codes

The following ambulance HCPCS codes are subject to prior authorization:

- A0426 - Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport

The mileage code, A0425, will be handled as an associated procedure for prior authorization processing and should always be billed in conjunction with the transport code. Prior authorization is not needed for A0425.

Prior Authorization Request Received for a Code Not Listed Above

No prior authorization decisions will be made on any code NOT on this list. If an A/B MAC receives a prior authorization request for a code not on this list, the A/B MAC will not review the request and will not issue a decision letter.

Chapter 4: Number of Trips

A provisional affirmative prior authorization decision affirms a specified number of trips within a specific amount of time.

- The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips (which equates to 80 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.
- A provisional 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.

Chapter 5: Submitting a Request

Submitters should include the following data elements in a PA request package:

Beneficiary Information

- Beneficiary Name,
- Beneficiary Medicare Number (also known as HICN),
- Beneficiary Date of Birth, and
- Beneficiary Gender

Certifying Physician/Practitioner Information

- Physician/Practitioner Name,
- Physician/Practitioner National Provider Identifier (NPI),
- Physician/Practitioner PTAN (optional), and
- Physician/Practitioner Address

Ambulance Supplier Information

- Ambulance Supplier Name
- Ambulance Supplier National Provider Identifier (NPI)
- Ambulance Supplier PTAN (optional), and
- Ambulance Supplier Address

Requestor Information

- Contact Name and
- Telephone Number

Other Information

- Number of transports requested,
- HCPCS Code,
- Submission Date,
- Start Date,
- Indicate if the request is an initial or resubmission review,
- Indicate if the request is expedited and the reason why, and
- State where the ambulance is garaged

Additional Required Documentation

- Physician Certification Statement,
- Documentation from the medical record to support the medical necessity of repetitive scheduled non-emergent ambulance transport,
- Information on the origin and destination of the transports, and
- Any other relevant document as deemed necessary by the A/B MAC to process the prior authorization.

Submitters should note that the start date they submit on the request is the date that will be used for the authorization start date.

Submitters are encouraged to use their respective MAC's form specifically designed for prior authorization requests. The form assists submitters with ensuring requests are complete.

Methods for sending a PA request package:

Submitters have four options for submitting prior authorization requests to the A/B MACs:

- Mail,
- Fax,
- Electronic submission of medical documentation (esMD), or
- MAC Provider Portal, if available.

For more information about esMD, see www.cms.gov/esMD or contact your A/B MAC.

Addresses and fax numbers of the A/B MACs:

- For suppliers garaged in New Jersey or Pennsylvania, send requests to A/B MAC JL at:
 - Fax Number: 1-877-439-5479
 - Mailing Address: Novitas Solutions
Part B Prior Authorization Request
PO Box 3702
Mechanicsburg, PA 17055or
 - Mailing Address: Novitas Solutions
Attention: Part B Prior Authorization Request
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050 - esMD: (indicate document type "81")
- For suppliers garaged in South Carolina, send requests to A/B MAC J11 at:
 - Fax Number: 803-462-2702
 - Mailing Address: Palmetto GBA – J11 MAC Prior Auth
PO Box 100212
Columbia, SC, 29202-3212- esMD: (indicate document type "81")

Possible Outcomes of Prior Authorization Request Review:

- Provisional affirmation (Chapter 6) or
- Non-affirmation
 - Incomplete request (Chapter 7)
 - Not medically necessary

Cases where Medicare is primary and another insurance company is secondary:

- Ambulance suppliers or beneficiaries may submit the claim without a prior authorization decision if the claim is non-covered (GY modifier). A prior authorization is not needed and the claim will not be developed due to the prior authorization model.
- Services billed as not medically necessary (GA modifier) will be developed and reviewed under the prior authorization model.

If an ambulance supplier or beneficiary chooses to use the prior authorization for a denial then the following process is to be followed:

- The submitter may submit the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the transport, then a non-affirmative prior authorization decision will be sent to the supplier and to the beneficiary advising them that Medicare will not pay for the service.
- A claim with a non-affirmed decision submitted to the A/B MAC for payment will be denied.
- The submitter may forward the denied claim to his/her secondary insurance payee as appropriate to determine payment for the transport.

Cases where another insurance company is primary and Medicare is secondary:

If an ambulance supplier plans to bill another insurance first and bill Medicare second, the submitter and beneficiary have two options:

1. Seek Prior Authorization:
 - The submitter submits the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the transport, then a provisional affirmative prior authorization decision will be sent to the supplier and to the beneficiary advising them that Medicare **will** pay for the transport.
 - The supplier renders the service and submits a claim to the other insurance company.
 - If the other insurance company denies the claim, the supplier or beneficiary can submit a claim to the A/B MAC (listing the prior authorization tracking number on the claim). The A/B MAC will pay the claim.
2. Skip Prior Authorization:
 - The supplier renders the service and submits a claim to the primary payer for a determination as appropriate.
 - If the other insurance company denies the claim, the supplier or beneficiary can submit a claim to the A/B MAC. The A/B MAC will stop the claim for pre-payment review and will send an Additional Documentation Request (ADR) letter. The supplier should respond to the ADR.

Timeframe for Decisions:

- The A/B MAC will postmark notification of the decision to the supplier and the beneficiary within 10 business days for an initial request.
- A resubmitted request is a request submitted with additional documentation after the initial prior authorization request was non-affirmed. The A/B MAC will postmark

notification of the decision of these requests to the supplier and the beneficiary within 20 business days.

- A supplier or beneficiary may request an expedited review when the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. The A/B MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of all applicable Medicare required documentation.
 - As this model is for non-emergent services, CMS expects requests for expedited reviews to be extremely **rare**.

Supplier Telephone Inquiries:

Suppliers who have questions about the prior authorization process should call the appropriate A/B MAC. The numbers for Customer Service Representatives at the A/B MACs are as follows:

- For suppliers garaged in New Jersey or Pennsylvania, call 855-340-5975.
- For suppliers garaged in South Carolina, call 855-696-0705.

See Appendices A and B

Chapter 6: A Provisional Affirmative Decision

Provisional Affirmative Decision

A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

Decision Letter(s):

The A/B MAC will send decision letters with the provisional affirmative prior authorization number to the submitter via fax, mail, or the MAC provider portal (when available) postmarked within 10 business days for initial requests and 20 business days for resubmitted requests. Decision letters sent via esMD are not available at this time. A copy of the decision letter will also be mailed to the beneficiary.

Non-Transferability of a provisional affirmative PA Decision:

- A provisional affirmative prior authorization decision does not follow the beneficiary.
- Only one ambulance supplier is allowed to request prior authorization per beneficiary per time period. If the initial supplier cannot complete the total number of prior authorized transports, the initial supplier should contact their MAC to cancel their prior authorization.
- A subsequent ambulance supplier may submit a prior authorization request to provide transport for the same beneficiary and must include the required documentation in the submission.

Supplier's Actions:

- Render the service to the beneficiary.
- Have all documentation available on request.
- Submit the claim with the tracking number on the claim.
 - The submission of the prior authorized transport claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the unique tracking number is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the unique tracking number is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.
 - If all requirements are met the claim will be paid.
 - The prior authorization model has specific parameters for pre-payment review; however other contractors (CERT, ZPICs, etc.) may have parameters outside of the prior authorization model that will suspend the same claim for another type of review. If your claim is selected for review, guidance and directions will be provided on the Additional Documentation Request Letter from the requesting contractor.

See Appendix A: Prior Authorization Request Process (Supplier Submits)

Chapter 7: A Non-Affirmative Decision for Incomplete Requests

An incomplete request is considered non-affirmed. When an incomplete request is submitted:

- The A/B MAC will provide notification of what is missing with the prior authorization request to the submitter via fax, mail, or the MAC provider portal (when available) through a detailed decision letter postmarked within 10 business days for initial requests and 20 business days for resubmitted requests. Decision letters sent via esMD are not available at this time. A copy of the decision letter will also be mailed to the beneficiary.
- The submitter may resubmit another complete package with all documentation required as noted in the detailed decision letter. See Chapter 8 for instructions on resubmitting a prior authorization request.
- If the claim is submitted to the A/B MAC for payment with a non-affirmative prior authorization decision, it will be denied.
 - All appeal rights are then engaged.
 - The claim could then be submitted to secondary insurance.

Suppliers Action:

- Use the detailed decision letter to ensure that the request package complies with all requirements.
 - Resubmit a prior authorization request, if appropriate.

Chapter 8: Resubmitting a Prior Authorization Request

- The submitter should review the detailed decision letter that was provided.
- The submitter should make whatever modifications are needed to the prior authorization package and follow the submission procedures.
- The A/B MAC will provide notification of the decision through a detailed decision letter postmarked within 20 business days of the review to the ambulance supplier and the beneficiary.

Chapter 9: Claim Submission Where Prior Authorization was Sought

Cases Where a Prior Authorization Request was Submitted and Affirmed:

- The submission of the prior authorized transport claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the unique tracking number is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the unique tracking number is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN.
- Series of claims:
 - Should be submitted with the prior authorization tracking number on the claim.
 - Should be submitted to the applicable A/B MAC for adjudication.
 - If the supplier changes during the scheduled transport period, the claim will undergo a complex medical review. The new supplier is required to submit all medical documentation to support a provisional affirmative prior authorization decision.

Cases Where a Prior Authorization Request was Submitted and Non-Affirmed:

- The submission of the prior authorized transport claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the unique tracking number is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the unique tracking number is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN.
- Series of claims:
 - Should be submitted with the prior authorization tracking number on the claim.
 - Should be submitted to the applicable A/B MAC for adjudication.
- If the claim is submitted to the A/B MAC for payment with a non-affirmative prior authorization decision, it will be denied.
 - All appeal rights are then engaged.
 - This claim could then be submitted to secondary insurance.

See Appendix C-Claim Line Process (if PA was sought)

Chapter 10: Claim Submission Where PA was NOT Sought: The Prepayment Review Process

If an applicable claim is submitted without a prior authorization decision, it will be stopped for pre-payment review. Claims with transports rendered before December 15, 2014 are not applicable for the prior authorization model.

At this time, suppliers do not need to do anything differently when submitting a claim without a unique tracking number. They do not need to put any information in the remarks field. They do not need to submit any unsolicited documentation.

Stopping a Claim for Pre-Payment Review:

- The A/B MAC will stop the claim and send an Additional Documentation Request (ADR) through the US Postal Service.
- The supplier will have 45 days to respond to the ADR with all requested documentation.
- The supplier can send the documentation via:
 - Fax
 - Mail
 - esMD (for more information see: www.cms.gov/esMD)
- The A/B MAC will have 60 days to review the documentation.

See Appendix D-Claim Line Process (if PA was not sought)

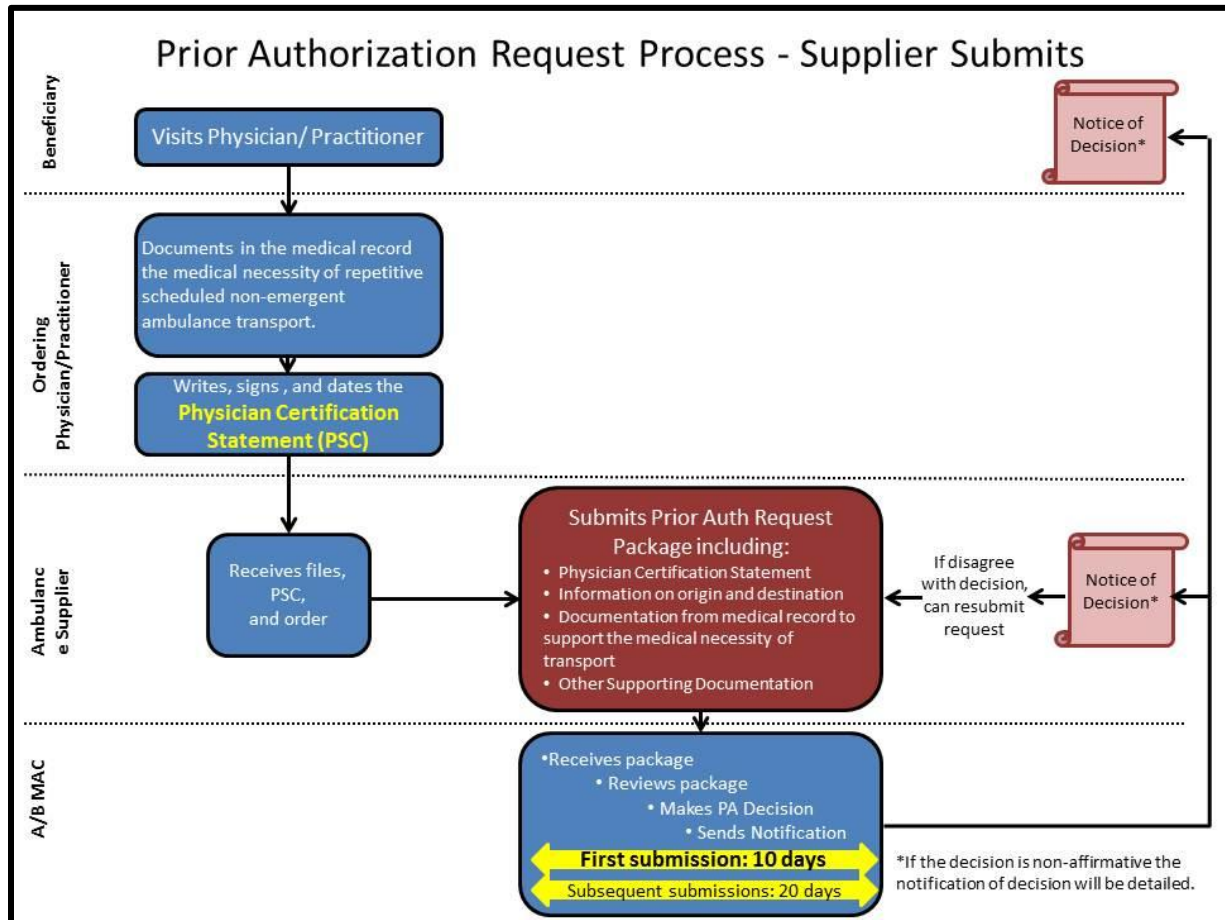
Chapter 11: Claim Appeals

Appeals follow all current procedures. For further information consult the Medicare Claims Processing Manual publication 100-04, chapter 29 Appeals of Claims Decision.

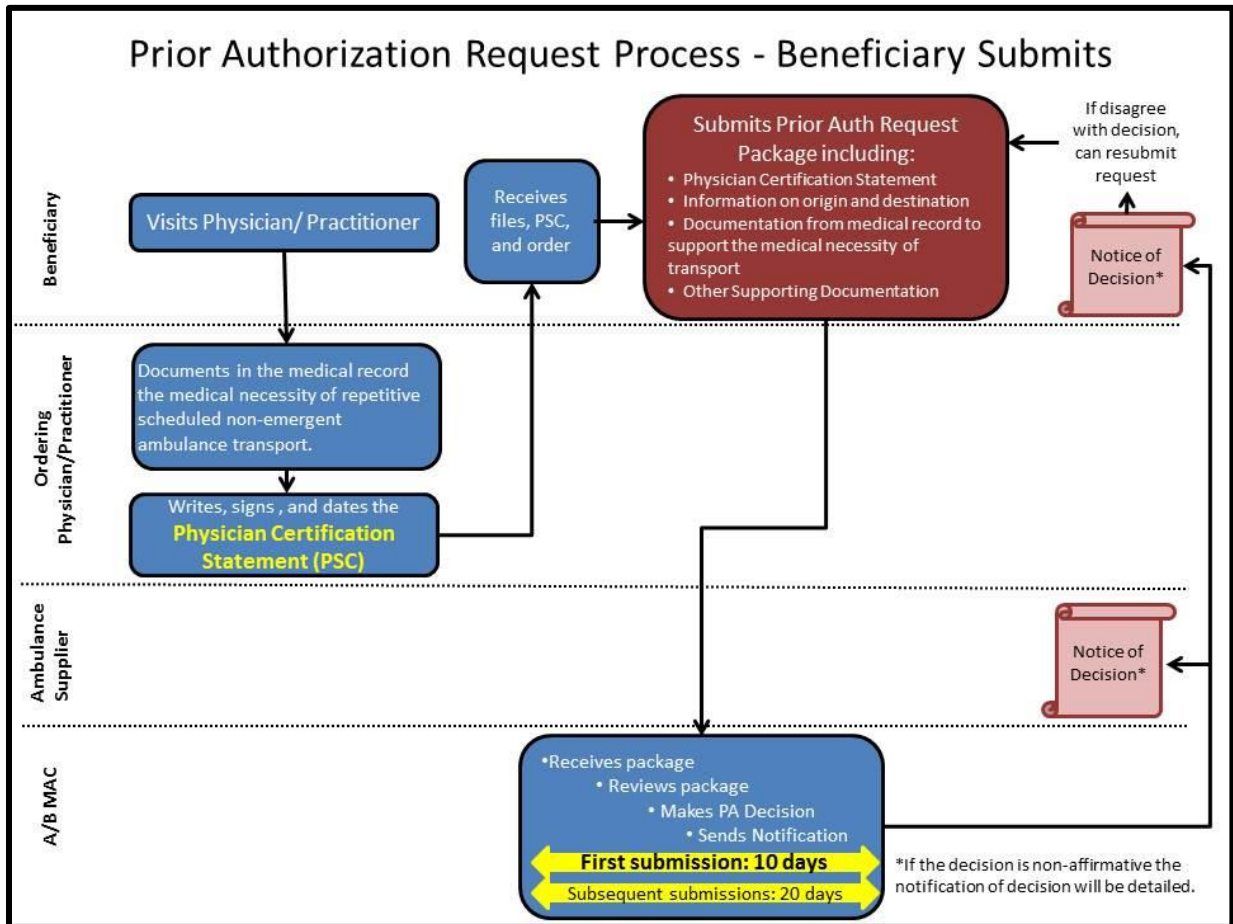
This prior authorization model does not include a separate appeal process for a non-affirmative prior authorization request decision.

However, a non-affirmative prior authorization request decision does not prevent the supplier from submitting a claim. Such a submission of a claim and resulting denial by the A/B MAC would constitute an initial determination that would make the appeals process available for disputes by beneficiaries and suppliers.

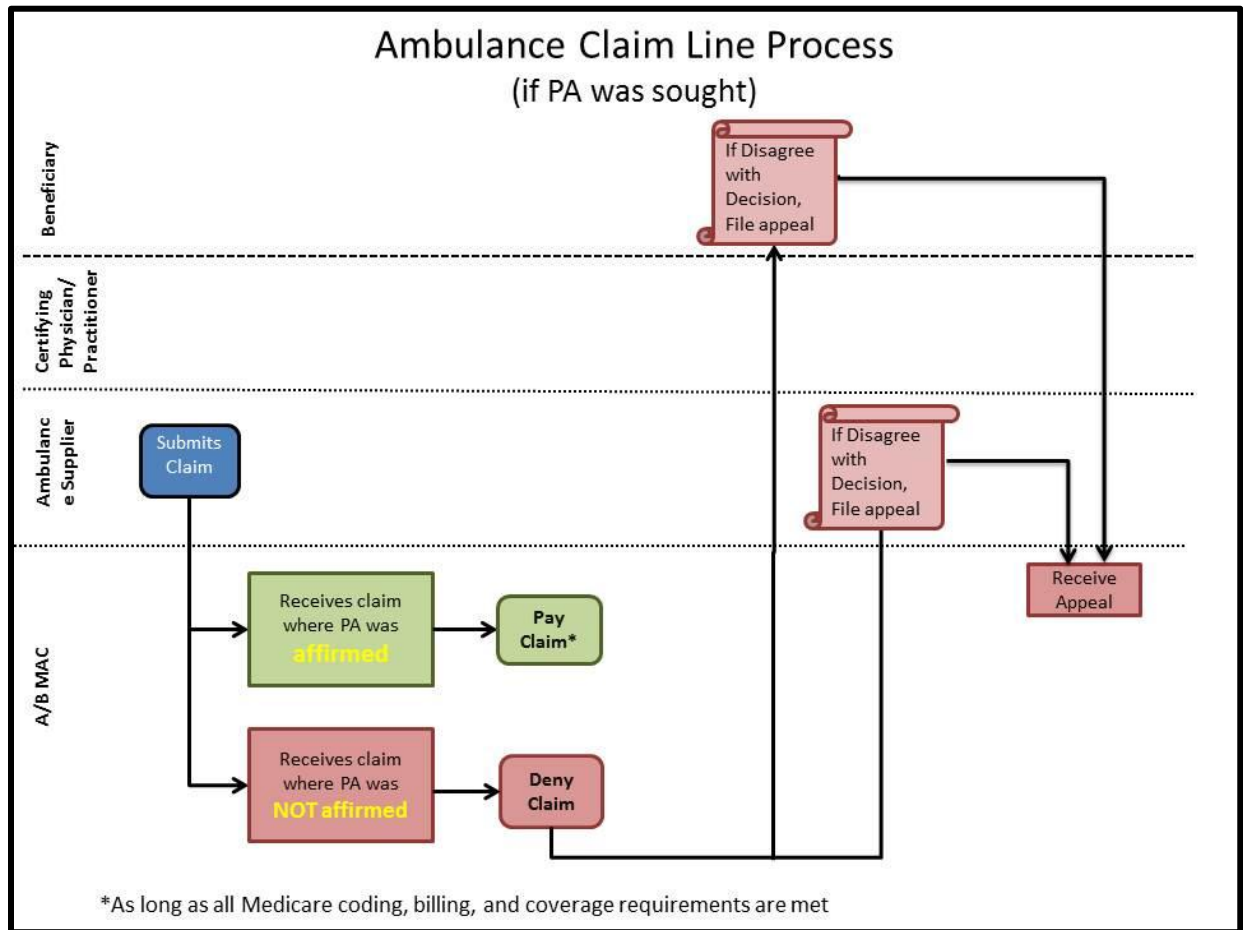
Appendix A: Prior Authorization Request Process (Supplier Submits)



Appendix B: Prior Authorization Request Process (Beneficiary Submits)



Appendix C: Claim Line Process (if PA was sought)



Appendix D: Claim Line Process (if PA was not sought)

