DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

Dear Physician/Practitioner:

The purpose of this letter is to inform you that the Medicare Fee-For-Service Program will start a three year **prior authorization model for repetitive scheduled non-emergent ambulance transports**. The goal of this program is to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments.

The new prior authorization process for repetitive scheduled non-emergent ambulance transports applies to independently enrolled ambulance suppliers garaged in the states of **New Jersey**, **Pennsylvania**, and **South Carolina**. On **December 1, 2014** ambulance suppliers garaged in these states may begin submitting prior authorization requests for transports occurring on or after **December 15, 2014**.

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

- Medical necessity requirements are met
- The ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that those medical necessity requirements were met (see 42 C.F.R. §410.40(d)(1) and (2))[1]

What You Need to Know

It is important to keep in mind that the prior authorization model does not create new documentation requirements for physicians/practitioners or suppliers – it simply requires the documentation to be submitted earlier in the claims process. **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.**

The non-emergent ambulance prior authorization model applies to the following Healthcare Common Procedure Coding System (HCPCS) codes:

- A0425 - BLS/ALS mileage (per mile) (*)

[1] 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.

- 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 will be handled as an associated procedure for prior authorization processing and should always be billed in conjunction with the transport code.

The ambulance supplier or beneficiary submits the prior authorization request with accompanying documentation to the appropriate A/B Medicare Administrative Contractor (MAC).

The prior authorization request must include **all relevant documentation to support Medicare coverage of the transport.** This includes, but is not limited to:

- Physician Certification Statement, including the certifying physician's name, National Provider Identifier (NPI), PTAN and address
- Procedure codes
- Number of transports requested
  - The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips per prior authorization request in a 60-day period
- 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
- Any other relevant document as deemed necessary by the A/B MAC to process the prior authorization

For more information on coverage and documentation requirements, please refer to:

- Jurisdiction 11 Ambulance Information
- Jurisdiction L LCD for Pennsylvania
- Jurisdiction L LCD for New Jersey

Additional information about the model is available at http://go.cms.gov/PAAmbulance.

If you have specific questions that are not addressed on this website please contact AmbulancePA@cms.hhs.gov.