

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



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- [“Guidelines for Teaching Physicians, Interns, and Residents”](#) Fact Sheet (ICN 006347), downloadable



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Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for independently enrolled Medicare ambulance suppliers who (1) provide repetitive scheduled non-emergent ambulance transports for Medicare Fee-For-Service beneficiaries in New Jersey, Pennsylvania, and South Carolina and (2) submit claims to Medicare Administrative Contractors (MACs) for ambulance services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) began a 3-year prior authorization model for repetitive scheduled non-emergent ambulance transports in the states of New Jersey, Pennsylvania, and South Carolina on December 1, 2014, for transports on or after December 15, 2014, regardless of the origin or destination of the transport.

CMS is issuing this Special Edition (SE) 1514 solely as an educational guide to improve compliance with documentation requirements for the repetitive scheduled non-emergent ambulance prior authorization model. SE1514 presents useful information that will help

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suppliers receive provisional affirmed decisions for prior authorization requests submitted for patients that meet coverage and medical necessity requirements.

See the Background and Additional Information Sections of this article for further details, and make sure that your billing staffs are aware of this information.

Background

Medicare covers ambulance services, including air ambulance (fixed wing and rotary wing) services, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The Medicare ambulance benefit for non-emergent transports is very limited and designed only for patients who are clinically unable to be transported by other means. Non-emergent transportation by ambulance is appropriate if either:

- (1) The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or
- (2) The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Therefore, bed confinement is not the sole criterion in determining the medical necessity of non-emergent ambulance transportation; rather, it is one factor that is considered in medical necessity determinations (See [42 CFR 410.40\(d\)\(1\)](#))

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips (or six one way trips) within a 10-day period, or at least once per week for at least 3 weeks.

Repetitive transportation services are often needed by beneficiaries receiving dialysis, covered wound care, treatment interventions or cancer treatment. For wound care, it is anticipated that wound care is managed in the home and requires only periodic clinic appointments for:

- Debridement,
- Wound management, or
- Infection types of services.

In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health (whether or not such other transportation is actually available), no payment may be made for ambulance services. In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service.

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

- (1) The medical necessity requirements described previously are met (that is, bed confinement or medically required); and

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(2) The ambulance provider/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.

Note: Per 42 CFR §410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished (See [42 CFR 410.40\(d\)\(2\)](#)). **The written order is often referred to as a Physician Certification Statement (PCS).**

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 CFR 410.40 and [42 CFR 410.41](#) and in the "Medicare Benefit Policy Manual", [Chapter 10](#).

Under this model, an ambulance supplier or beneficiary is encouraged to submit to their MAC a request for prior authorization along with all relevant documentation to support Medicare coverage of a repetitive scheduled non-emergent ambulance transport.

Note that prior authorization does not create new clinical documentation requirements. Instead, it requires the same information necessary to support Medicare payment, just earlier in the process.

Prior authorization allows ambulance suppliers to address issues with claims prior to rendering services and to avoid an appeal process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

Submitting a prior authorization request is voluntary. However, if prior authorization has not been requested by the fourth round trip, the claims will be stopped for pre-payment review. After receipt of all relevant documentation, the MAC will make every effort to conduct a review and postmark (or fax if a fax number is provided) the notification of their decision on a prior authorization request within 10 business days for an initial submission.

PCS and Documentation that Facilitates an Affirmative Decision

In order to be provisionally affirmed, the request for prior authorization must meet all applicable rules and policies, and any applicable Local Coverage Determination (LCD) requirements for ambulance transport claims.

- Make sure the PCS is completed for the particular beneficiary and must not be more than 60 days prior to the requested start date. Only conditions specific for the beneficiary should be noted and all applicable comments should concern the beneficiary's current condition.
- Make sure all signatures are legible and/or there is a signature log for the physician's signature.

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- Make sure the relevant documentation received from the ordering physician's medical records provides a clear picture of the beneficiary's current condition requiring ambulance transport. The documentation must not be more than 60 days prior to the requested start date. This information must be from the physician, not the ambulance supplier.

The top reasons for non-affirmations are as follows:

- A PCS was not submitted, was not signed, was missing credentials, was incomplete or was more than 60 days prior to the requested start date.
- Medical documentation was not submitted with the PCS.
- Medical documentation submitted did not support what was included on the PCS.
- Medical documentation submitted was not current (more than 60 days prior to the requested start date), did not include the patient's name, or in some cases, was not legible.

Key items to be addressed

1. PCS

- The PCS must be signed and dated by the patient's attending physician.
- The signature, credentials, and date must be readable.
- The prefix "Dr." is a title and not a credential.
- Stamped signatures or file signatures are not acceptable.
- The PCS cannot be dated more than 60 days in advance of the requested start date.
- The PCS information must be verifiable.
- Medical documentation must be attached that supports the PCS and that describes the beneficiary's condition(s) that necessitate(s) the type and level of ambulance transports.
- A signed and dated PCS does not, by itself, demonstrate that the repetitive scheduled transports are medically necessary.

2. Medical Documentation

- Medical documentation should provide sufficient information to support the prior authorization request form and the PCS.
- Documentation should:
 - Reveal the medical necessity of the type and level of transport services.
 - Reveal the exact origin address and destination address.

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- Specify the beneficiary, provider and date of service.
- Capture the “what” and “why” of a beneficiary’s condition(s) that necessitate(s) the transports.
- Support the diagnoses or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code(s) on the PCS with clinical assessment data and objective findings.
- Be readable and dated no earlier than 60 days in advance of the requested start date.
- Documentation can include, but is not limited to:
 - Doctor's progress notes,
 - Nursing notes,
 - History and Physical Exam, and
 - Physical or occupational therapy notes.
- For admission and discharge summaries for a condition itemized on the PCS, the documentation must contain statements that capture the “what” and the “why” (for example, if a patient’s condition is bed-confined, documentation must indicate why the patient is bed-confined).
- The documentation should not contradict the PCS (for example, patient is indicated as bed-confined on PCS, however, medical records document the patient uses a wheelchair).

Example of Documentation that Identifies the “What” and the “Why”

Included in the Progress Note:

Patient is an 80 year old white male with a history of ESRD being treated with hemo-dialysis at ABC Dialysis Center. Wegener’s Disease, Atrial Fibrillation, severe osteoporosis, and Spinal Stenosis all treated by Dr. Smith. Recently, patient has had “bouts” of pneumonia. Patient has extremely fragile bones, to the point that any lifting of the patient even with a “Hoyer Lift” can and has resulted in dislocations and fractures. Patient has bilateral elbow flexion of 30 degrees, reduced plantar strength with a max of 1 out of 5 bilaterally and 0 degree max hip flexion bilaterally. Bilateral knee flexion is 0 degree. Patient is Alert and Oriented x4 at baseline with a GCS of 15.

Patient requires assistance in the areas of bathing, dressing, toileting and cleaning himself, transferring, unable to get up from bed, and feeding. Patient does not exercise any control over urination and defecation.

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Patient is completely bed-confined. Due to contractures, weakness, and over deconditioning, patient is unable to ambulate, sit or stand. Based on the physical assessment and the physical limitations noted, the patient is on fall precautions from bed.

This patient requires stretcher for transport due to non-weight bearing, non-ambulatory, bed confined status, and patient cannot support himself for any amount of time. Monitoring is required to prevent injury or fall from stretcher.

Note: For those in New Jersey and Pennsylvania, you may want to review Local Coverage Determination (LCD) [L32252](#) published by the MAC, Novitas Solutions.

Methods for Sending a Prior Authorization (PA) Request Package to Your MAC

Submitters have four options for submitting PA requests to their MACs:

1. Fax,
2. Mail,
3. Electronic Submission of Medical Documentation (esMD), or
4. MAC Provider Portal, if available.

For more information about esMD, see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html> on the CMS website, or contact your MAC.

Addresses and Fax Numbers of the MACs

1. For suppliers garaged in New Jersey or Pennsylvania, send requests to the MAC JL at:
 - Fax Number: 1-877-439-5479
 - Mailing Address: Novitas Solutions
Part B Prior Authorization Request
PO Box 3702
Mechanicsburg, PA 17055

or

 - Mailing Address: Novitas Solutions
Attention: Part B Prior Authorization Request
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050
 - Electronic Submission of Medical Documentation (esMD): (indicate content type “81”)
2. For suppliers garaged in South Carolina, send requests to the MAC J11 at:
 - Fax Number: 803-462-2702
 - Mailing Address: Palmetto GBA – J11 MAC Prior Authorization
PO Box 100212

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- Electronic Submission of Medical Documentation (esMD): (indicate content type “81”)

Additional Information

If you have questions, please contact your MAC at their toll-free number. The number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work?

Links to the (1) JL New Jersey and Pennsylvania MAC Novitas Solutions' Ambulance Prior Authorization Website, and the (2) J11 South Carolina MAC Palmetto's Ambulance Prior Authorization Websites are available at <http://go.cms.gov/PAAmbulance> on the CMS website.

Questions can also be sent to the following CMS email address:

AmbulancePA@cms.hhs.gov

You may want to review the following:

- [“Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport”](#), and
- [Ambulance Prior Authorization Frequently Asked Questions \(FAQs\)](#).

For more operational details about the prior authorization of repetitive scheduled non-emergent ambulance transport model please see the [Ambulance Prior Authorization Operational Guide](#).

A letter ambulance suppliers can share with physicians and other entities to help obtain the necessary documentation in a timely manner can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/AmbulancePriorAuth_Physician-Letter_032415.pdf on the CMS website.

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