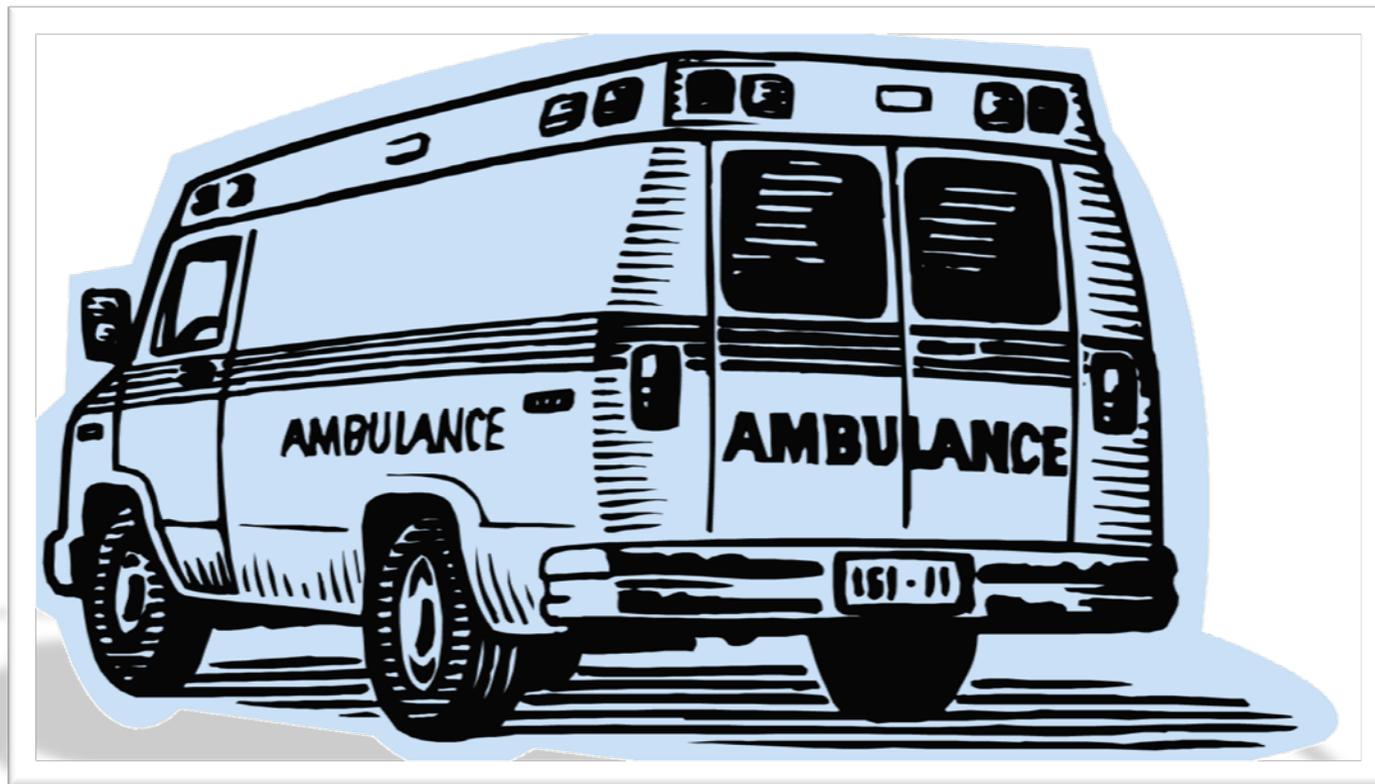


Prior Authorization of Repetitive Non-Emergent Ambulance Transport



Purpose

- To establish a three year prior authorization process for repetitive scheduled non-emergent ambulance transport
- To ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments to protect the Medicare Trust Fund by granting provisional affirmation for a service prior to submission of the claim

Prior Authorization

- 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 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 service is rendered

Definition of Repetitive Ambulance Service

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

Who and What?

- Who:
 - Ambulance provider/suppliers that are not institutionally based that provide Part B Medicare covered ambulance services and are enrolled as an independent ambulance provider/supplier
- What:
 - Repetitive scheduled non-emergent ambulance transport claims billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction

When and Where?

- When:
 - The model will begin in the Fall 2014
 - Where:
 - New Jersey
 - Pennsylvania
 - South Carolina
- Location based on where the ambulance is garaged

Medical Necessity 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 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

Coverage and Documentation Requirements

- Medicare coverage policies are unchanged
- Documentation requirements are unchanged
- Time frames for transport are unchanged

The model does NOT create any new documentation requirements.

It simply requires the information be submitted earlier in the claims process.

Current requirements can be found on the A/B MAC websites.

Also Unchanged

- The A/B MACs conduct these reviews
- All Advanced Beneficiary Notice (ABN) policies
- Claim appeal rights

What Has Changed?

- The provider/supplier 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

Prior Authorization Request Content

(As of July 31, 2014)

- Request needs to identify:
 - The Beneficiary's Name, Medicare Number, and Date of Birth
 - The Physician's Name, National Provider Identifier (NPI) and Address
 - The Provider/Supplier's Name, NPI and Address
 - Procedure Codes
 - Submission Date
- Request needs to include:
 - Physician 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 the origin and destination of the transports
 - Any other relevant document as deemed necessary by the Contractor to process the prior authorization

Number of Trips

- 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
- 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

Prior Authorization Request Submission

- Provider/Supplier or the beneficiary may submit the request
- The request can be:
 - Mailed (check A/B MAC website for address)
 - Faxed (check A/B MAC website for fax number)
 - Submitted through the Electronic Submission of Medical Documentation (esMD) system*

* More info about Electronic Submission of Medical Documentation (esMD) can be found at www.cms.gov/esMD.

Review Timeframes

- Initial Requests
 - The A/B MAC makes every effort to review request and postmark decision letters within **10 business days**
- Subsequent Requests
 - The A/B MAC makes every effort to review request and postmark decision letters within **20 business days**
- Emergent Circumstances
 - The A/B MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of all applicable Medicare required documentation

Detailed Decision Letter

- Decision letters are sent to:
 - Provider/Supplier
 - Beneficiary – Upon Request
- Decision letters that do not affirm the prior authorization request will:
 - Provide a detailed written explanation outlining which specific policy requirement(s) was/were not met

When a Prior Authorization Request is Submitted but Non-Affirmed

- A submitter can:
 - Resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request
 - or**
 - Provide service and submit a claim
 - The claim will be denied
 - All appeal rights are available

Resubmission and Appeals

- For non-affirmed prior authorization requests, unlimited resubmissions are allowed
 - These requests are not considered appeals
- For denied claims, all normal appeal rights apply

What Happens if I Don't Use the Prior Authorization Process?

- Pre-Payment Review....
 - If a provider/supplier has not requested prior authorization before the fourth round trip in a 30-day period
 1. The subsequent claims will be stopped for prepayment review
 - A/B MAC sends Additional Request letter and waits **45** days for a response
 - A/B MAC reviews submitted documentation within **30** days
 2. Without a prior authorization decision, the provider/supplier or the beneficiary will not know whether Medicare will pay for the service (and the provider/supplier or beneficiary may be financially liable)

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

Scenarios

	Prior authorization request is:	The A/B MAC decision is:	The supplier chooses to:	The A/B MAC will:
1	Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met)
2	Submitted	Non- Affirmative	a. Submit a claim b. Fix and resubmit a PA request	a. Deny the claim
3	Not submitted	N/A	Submit a claim	<ul style="list-style-type: none"> • Develop the claim • Pre-Pay Review the claim

Beneficiary Impact

- The service benefit is not changing
- Beneficiaries, upon request, will receive a notification of the decision about their prior authorization request

References on Service from the A/B MACs

- New Jersey and Pennsylvania
 - Jurisdiction JL: Novitas
 - <http://www.novitas-solutions.com>
 - Accepts esMD transactions
- South Carolina
 - Jurisdiction J11: Palmetto GBA Columbia
 - <http://www.palmettogba.com/medicare>
 - Accepts esMD transactions

CMS Resources

- Model Web Site: <http://go.cms.gov/PAAmbulance>
 - Fact Sheet
 - Frequently Asked Questions
 - Background
 - Information on Open Door Forums

Summary

Where:	NJ, PA, SC
The model begins:	Fall 2014
Submitted by:	Provider/Supplier or Beneficiary
Ends:	3 year model

For More Information

Email the Prior Authorization Team:	AmbulancePA@cms.hhs.gov
CMS Model Website:	http://go.cms.gov/PAAmbulance
FAQs:	See model website
Open Door Forums:	August 5, 2014



Questions?