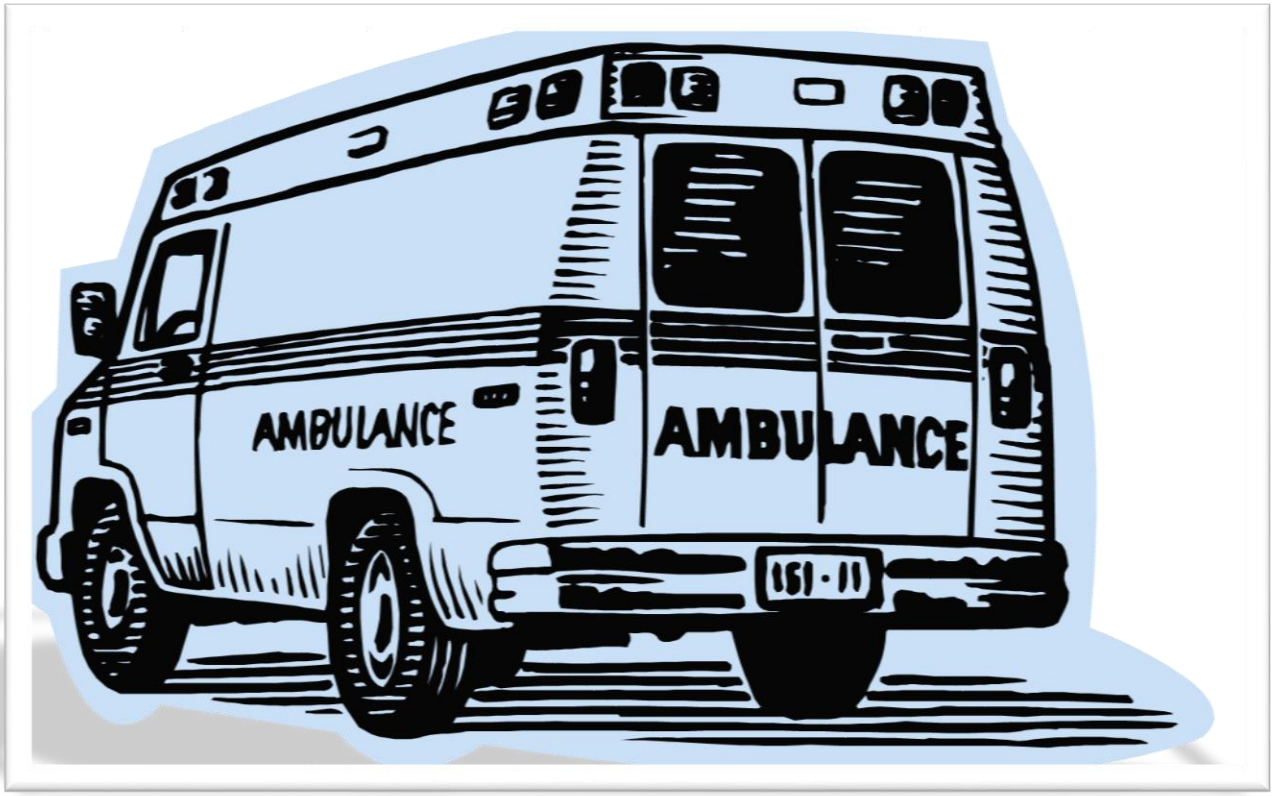
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Prior Authorization of Repetitive Non-Emergent Ambulance Transport



Open Door Forum: November 10, 2015

Purpose

- To establish a prior authorization process for repetitive scheduled non-emergent ambulance transports

- 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

What is 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 make sure 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 or cancer treatment.

Who and What

- Who:
  - Ambulance suppliers that are not institutionally based that provide Part B Medicare covered ambulance services and are enrolled as an independent ambulance supplier
  - Ambulance suppliers under review by a Zone Program Integrity Contractor are **not** eligible to submit prior authorization requests
- What:
  - Repetitive scheduled non-emergent ambulance transport claims billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction
  - Ambulance transports **not** included:
    - All transports included in a covered Part A stay
    - All transports provided by an institutionally based ambulance provider

Where and When

- **South Carolina, New Jersey,** and **Pennsylvania**
  - Began in December 2014
- **Delaware, the District of Columbia, Maryland, North Carolina, Virginia,** and **West Virginia**
  - Medicare Administrative Contractors (MACs) will begin accepting prior authorization requests on **December 15, 2015** for repetitive scheduled non-emergent ambulance transports scheduled to occur on or after January 1, 2016.
  - All repetitive scheduled non-emergent ambulance transports with a date of service on or after **January 1, 2016** must have completed the prior authorization process or the claims will be stopped for pre-payment review.
- Location is based on where the ambulance is garaged.

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, does not require prior authorization. It is paid only when either A0426 or A0428 is covered.
- No prior authorization decisions will be made on any code NOT on this list. If an MAC receives a prior authorization request for a code not on this list, the MAC will not review the request and will not issue a decision letter.

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 MAC websites.

Also Unchanged

- The MACs conduct these reviews
- All Advanced Beneficiary Notice (ABN) policies
- Claim appeal rights
- Dual eligible coverage
- Private insurance coverage

What Has Changed

- The ambulance supplier will know BEFORE THE SERVICE IS RENDERED whether Medicare will pay for the service.
- The beneficiary will be notified BEFORE THE SERVICE IS RENDERED whether Medicare will pay for the service.

Prior Authorization Request Content
(As of November 1, 2015)

- Request needs to identify:
  - The beneficiary's name, Medicare Number, date of birth and gender;
  - The certifying physician's name, National Provider Identifier (NPI), and address;
  - The ambulance supplier's name, NPI, and address;
  - The requestor's name, telephone number, and fax number;
  - Procedure codes;
  - Submission date;
  - Start of 60-day period;
  - State where the ambulance is garaged;
  - Indicate if the request is an initial or resubmission review; and
  - Indicate if the request is expedited and the reason why.

Prior Authorization Request Content Cont.
(As of November 1, 2015)

- 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; and
  - Any other relevant document as deemed necessary by the MAC 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.

- 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.

Prior Authorization Request Submission

- The ambulance supplier or the beneficiary may submit the request.
- The request can be:
  - Mailed (check MAC website for address);
  - Faxed (check MAC website for fax number);
  - Submitted through the MAC provider portal, when available; or
  - Submitted through the Electronic Submission of Medical Documentation (esMD) system*.
- 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.

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

Review Timeframes

- **Initial Requests**
  - The first prior authorization request for any 60 day period
  - The MAC makes every effort to review request and postmark decision letters within **10 business days**
- **Resubmitted Requests**
  - The request submitted with additional documentation after the initial prior authorization request was non-affirmed
  - The MAC makes every effort to review request and postmark decision letters within **20 business days**
- **Expedited Circumstances**
  - The request submitted when the standard timeframe could jeopardize the life or health of the beneficiary; however, under this model this should be extremely rare.
  - The MAC will make reasonable efforts to communicate a decision within **2 business days.**

Detailed Decision Letter

- Decision letters are sent to:
  - Ambulance supplier; and
  - Beneficiary.
- Decision letters include the prior authorization unique tracking number that must be submitted on the claim.
- 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.

Unique Tracking Number

- Medicare Administrative Contractors will list the prior authorization unique tracking number on the decision letter.
- This tracking number **must** be submitted on the claim.
- When submitting an electronic 837 professional claim, the unique tracking number (UTN) must be submitted in the 2300 Claim Information loop in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).
- When submitting a paper CMS 1500 Claim form, the unique tracking number (UTN) must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.

Non-Affirmed Prior Authorization Requests

- If a prior authorization request is non-affirmed:

1. The submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request
    - Unlimited resubmissions are allowed
    - Prior authorization decisions cannot be appealed

or

2. The submitter can provide the service and submit a claim
    - The claim will be denied
    - All appeal rights are available

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

- Pre-Payment Review….
  - If an ambulance supplier has not requested prior authorization before the fourth round trip
    1. The subsequent claims will be stopped for pre-payment review
       - MAC sends Additional Request letter and waits **45** days for a response
       - MAC reviews submitted documentation within **60** days
    2. Without a prior authorization decision, the supplier or the beneficiary will not know whether Medicare will pay for the service (and the supplier or beneficiary may be financially liable)

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

Scenarios

	Prior authorization request is:	The MAC decision is:	The supplier chooses to:	The 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	Stop the claim for pre-payment review

Beneficiary Impact

- The service benefit is not changing
- Beneficiaries will receive a notification of the decision about their prior authorization request
- Dual eligible coverage is not changing
- Private insurance coverage is not changing

References on Service from the MACs

- Delaware, the District of Columbia, Maryland, New Jersey, and Pennsylvania
  - Jurisdiction JL: Novitas Solutions
    - http://www.novitas-solutions.com
    - Accepts esMD transactions
- North Carolina, South Carolina, Virginia, and West Virginia
  - Jurisdiction JM: 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
  - Operational Guide
  - Letter to the Physician
- Code of Federal Regulations (42 C.F.R. §§410.40, 410.41: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/downloads/cfr410_40.pdf

For More Information

CMS Model Website:	http://go.cms.gov/PAAmbulance
FAQs:	See model website
Open Door Forum Transcript :	Available in approximately two weeks
Email the Prior Authorization Team:	AmbulancePA@cms.hhs.gov

Questions?