



Dear Physician/Practitioner:

The Medicare Fee-For-Service Program implemented a **prior authorization program for repetitive, scheduled non-emergent ambulance transports** that was recently extended through December 1, 2020. 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 prior authorization process for repetitive, scheduled non-emergent ambulance transports began on December 1, 2014 in New Jersey, Pennsylvania, and South Carolina. On January 1, 2016, the program added the states of Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips during a 10-day period; or at least one round trip per week for at least 3 weeks. Medicare may cover repetitive, scheduled, non-emergent transportation by ambulance if

- Medical necessity requirements are met, and
- 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.¹

What You Need to Know

It is important to keep in mind that the prior authorization program 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 program applies to the following Healthcare Common Procedure Coding System (HCPCS) codes:

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

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.

The ambulance supplier or beneficiary submits the prior authorization request with accompanying documentation to the appropriate 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:

- Documentation from the medical record to support the medical necessity of repetitive, scheduled non-emergent ambulance transport
 - Documentation must show transportation by other means is contraindicated
 - Vague statements, such as “patient is bed-confined”, are insufficient
 - Diagnosis of disease or illness may not be enough without corroborating evidence/statements
 - Attestation statements concerning the patient’s requirements for ambulance transportation are not sufficient without corroborating evidence in the medical documentation
- Physician Certification Statement (PCS), including the certifying physician’s name, National Provider Identifier and address
 - The PCS must be supported by the medical documentation
 - Bed-confinement or need for transportation cannot only be stated on the PCS
- 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
- Information on the origin and destination of the transports
- Any other relevant document as deemed necessary by the MAC to process the prior authorization

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

- [MAC Jurisdiction M Palmetto Ambulance Information](#) or
- [MAC Jurisdiction L Novitas Local Coverage Determination \(L35162\)](#).

If your patient does not qualify for Medicare transportation, there may be other state and local services that can help. Beneficiaries, case managers and care givers may contact Eldercare at 1-800-677-1116 or their local State Health Insurance Assistance Program. Beneficiaries can also find additional information in the Ambulance Prior Authorization Introductory letter posted on the program website listed below.

Additional information about the program is available at <http://go.cms.gov/PAAmbulance>. If you have specific questions that are not addressed on this website please submit questions via e-mail to AmbulancePA@cms.hhs.gov.