

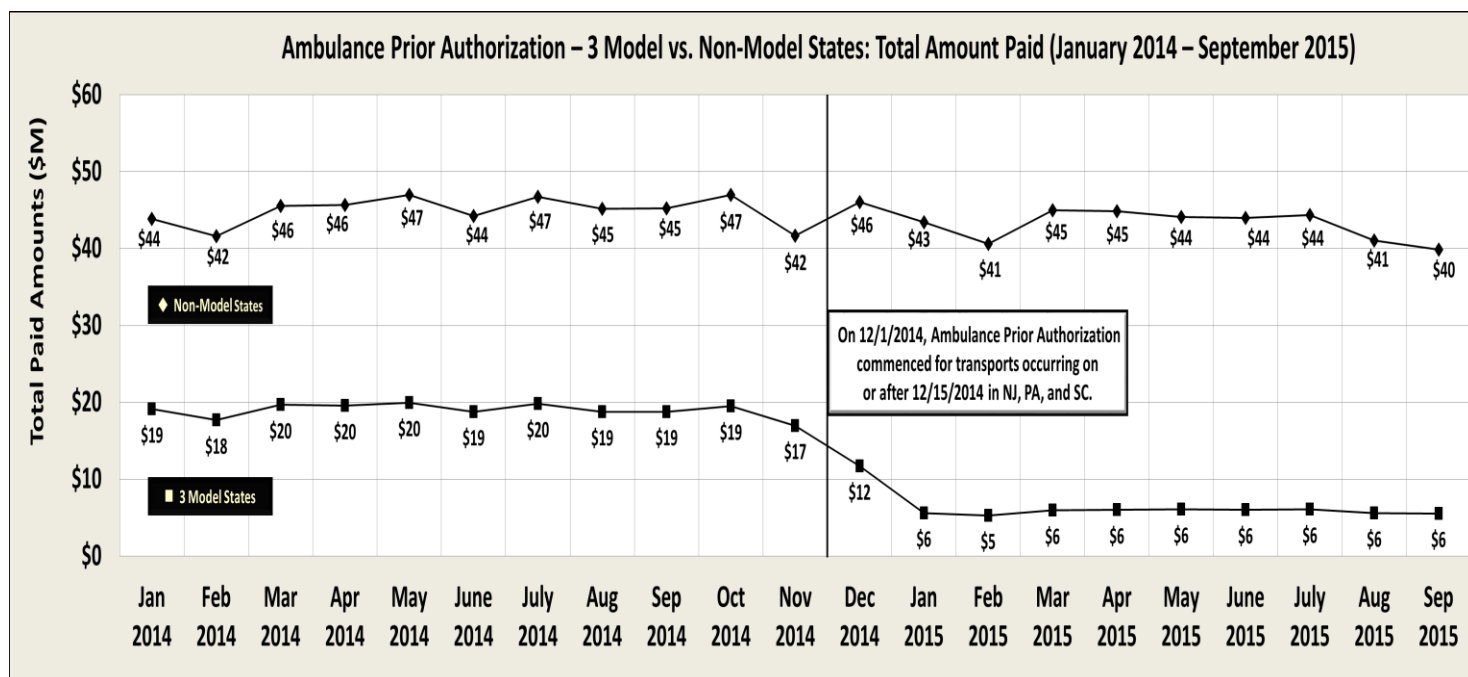
## Medicare Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport Model Status Update (Posted 04-07-2016)

The Medicare Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport Model began on December 15, 2014 in Pennsylvania, New Jersey, and South Carolina. Prior authorization does not create new clinical documentation requirements nor change any existing Medicare coverage policies.

The Centers for Medicare & Medicaid Services (CMS) believes using a prior authorization process will help make sure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered to the beneficiaries and before claims are submitted for payment.

### Preliminary Data

As seen in the chart below, CMS has observed a decrease in expenditures for repetitive scheduled non-emergent ambulance transports in the model states since implementation.



**3 Model States:** New Jersey, Pennsylvania, and South Carolina

**Claim Paid Date:** Between 01/01/2014 and 01/15/2016

**Note:** Practitioners have up to one calendar year after the date of service to submit claims. Consequently, the total amounts paid represented in the right hand side of this chart will generally continue to increase as it can take up to 12 months for the claims figures to reach 100% completeness.

### Codes:

- A0425 - Ground mileage, per mile
- A0426 - Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport

Prior to the model, spending on repetitive schedule non-emergent ambulance transports in the model states averaged \$18.9 million per month. Based on data from the first year of the model, spending decreased to an average of \$5.4 million per month.

In the first year of the model, 18,367 prior authorization requests were received and finalized. Of those 18,367 requests, 6,430 were affirmed. Repetitive scheduled non-emergent ambulance transports were approved for all beneficiaries who met all the requirements. Submitters have unlimited opportunities to resubmit requests to include all necessary and relevant documentation needed for an affirmed decision. Affirmation rates have increased in the recent months as ambulance suppliers and physicians better understand the prior authorization process and documentation requirements. In cases where the beneficiary's condition does not meet Medicare's coverage requirements, CMS provides the beneficiary with contact information for state and local agencies that may be able to assist with identifying alternative transportation arrangements.

CMS will continue to closely monitor and evaluate the effectiveness of the model. An evaluation will be conducted as required by Section 1115A of the Social Security Act.