New Prior Authorization Demonstration Projects for Repetitive Scheduled Non-Emergent Ambulance Transport

Frequently Asked Questions

1. **What is prior authorization?**

   Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before service is furnished 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 help ensure proper payment before the service is rendered.

2. **Does prior authorization create new documentation requirements?**

   Prior authorization does not create new documentation requirements. Prior authorization would simply require currently mandated documentation earlier in the claims payment process.

3. **Under prior authorization, how long will Medicare have to affirm or non-affirm a prior authorization request?**

   Medicare will make every effort to postmark a decision on a prior authorization request within 10 business days for an initial request and 20 business days for a resubmitted request.

4. **Is the 10-day review period under prior authorization calendar days or business days?**

   The 10-day review period is business days. Medicare Administrative Contractors will make every attempt to review initial prior authorization requests in 10 business days and resubmitted prior authorization requests in 20 business days.

5. **In what cases could a provider, supplier, or beneficiary request an expedited review?**

   A provider, supplier, or beneficiary may request an expedited review when the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. Medicare Administrative Contractors will make reasonable efforts to communicate a decision within 2 business days of receipt of all applicable Medicare required documentation. As these models are for non-emergent services, CMS expects requests for expedited reviews to be extremely rare.

6. **Will there be a tracking number for each prior authorization decision?**

   Yes, Medicare Administrative Contractors will list the prior authorization tracking number on the decision notice. This tracking number must be submitted on the claim.

7. **Is there a way to expedite the payment of a claim under prior authorization?**

In most circumstances, a claim that has been prior authorized will not be stopped for prepayment review and therefore not subject to any delay. However, normal claims processing timelines still apply, which require that Medicare Administrative Contractors wait a minimum numbers of days before issuing payment.

8. Will these claims still be subject to additional post pay review?

Generally, the claims that have a prior authorization decision will not be subject to additional review. However, CMS contractors, including Zone Program Integrity Contractors and Medicare Administrative Contractors, may conduct targeted pre- and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process, such as documentation showing proof of delivery and/or accessories. In addition, the Comprehensive Error Rate Testing contractor must review a random sample of claims for post payment review.

9. For prior authorization, who will make the decision on the prior authorization request?

Medicare Administrative Contractors will make these decisions.

10. How will CMS administer prior authorization? Is there specialized staff devoted to the program?

The prior authorization is administered by the Medicare Administrative Contractors, the same contractors that currently process claims and conduct medical review on part B services. Clinical staff are assigned to medical review and trained to ensure consistency. In addition, we will employ private sector standards in our prior authorization program such as responding to prior authorization requesters within 10 days of receipt of an initial prior authorization package, providing responses that are specific about missing information and giving providers an opportunity to resubmit the prior authorization package for re-review. During re-submission the contractor has 20 business days for review.

11. Will prior authorization allow for electronic submission of prior authorization requests?

Yes. Submitters who choose to utilize the prior authorization process may send prior authorization requests to the Medicare Administrative Contractors via mail, fax, or through the Electronic Submission of Medical Documentation (esMD) system. More information can be found at http://www.cms.gov/esMD.

12. When will CMS provide operational details related to prior authorization?

Prior authorization operational details are forthcoming and will be discussed on upcoming Open Door Forum Calls. Our website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html will provide additional operational details.

13. Where can I send additional questions?

Additional questions on the prior authorization model can be sent to CMS at AmbulancePA@cms.hhs.gov.

14. What does the prior authorization model do?

The model establishes a prior authorization process for repetitive scheduled non-emergent ambulance transport to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care.

15. What states would this model impact?

This prior authorization model will impact the states of New Jersey, Pennsylvania, and South Carolina based on where the ambulance is garaged.

16. Why did CMS choose these three states?

New Jersey, Pennsylvania, and South Carolina were selected for initial implementation of this process because of their high utilization and improper payment rates. The June 2013 Medicare Payment Advisory Commission's (MedPAC) Report to Congress: "Medicare and the Health Care Delivery System," found that six states had higher than average spending on non-emergent ambulance transport per dialysis beneficiary than other states. When these six states were ranked by total Medicare expenditures on Non-Emergent Ambulance services, New Jersey, Pennsylvania, and South Carolina were in the top three.

17. Why did CMS choose to test this model on repetitive scheduled non-emergent ambulance transport?

According to the Government Accountability Office "Cost and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased" the number of Basic Life Support non-emergent transports for Medicare fee-for-service beneficiaries increased by 59 percent from 2004 to 2010. This increase is a cause for concern.

The Department of Health and Human Services Office of Inspector General (OIG) has published numerous reports about Medicare's ambulance benefit and has concluded that this benefit is highly vulnerable to abuse. A 2006 OIG study, "Medicare Payment for Ambulance Transport" evaluated the appropriate use of the ambulance benefit and the findings indicated a 20 percent nationwide improper payment rate for non-emergent ambulance transport, meaning 20 percent of non-emergent transports did not meet Medicare's coverage requirements. The report recommended that CMS implement activities to reduce these improper payments.

In addition, in June 2013, MedPAC published a report that included an analysis of non-emergent ambulance transports to dialysis facilities. Transports to and from dialysis facilities have grown noticeably in recent years and represent a large share of non-emergent ambulance claims. In the 5-year period between 2007 and 2011, the volume of transports to and from a dialysis facility increased 20 percent, more than twice the rate of all other ambulance transports combined. In 2011, ambulance transports to and from dialysis facilities

accounted for nearly $700 million in Medicare spending, or approximately 13 percent of Medicare expenditures on ambulance services.

18. How many trips are allowed without prior authorization before the pre-payment review begins?

If a prior authorization has not been requested before the fourth round trip in a 30-day period, claims will be subject to pre-payment medical review. CMS will monitor utilization patterns to ensure that providers/suppliers of ambulance services are not routinely limiting needed services to a certain number of trips per 30-day period in order to avoid the prior authorization process. CMS believes that the repetitive scheduled non-emergent ambulance transport trips for a beneficiary will generally be scheduled through one provider/supplier at the beginning of the authorization period.

19. How many ambulance providers or suppliers can request prior authorization for one beneficiary for one time period?

Under this model, CMS allows one ambulance provider/supplier to request prior authorization per beneficiary per time period. If the initial provider/supplier cannot complete the total number of prior authorized transports (e.g., initial ambulance company closes or no longer services that area), the initial provider or supplier's request is cancelled. In this situation, a subsequent ambulance provider or supplier may submit a prior authorization request to provide transport for the same beneficiary and must include the required documentation in the submission.

If multiple ambulance provider/suppliers are providing transports to the beneficiary during the same or overlapping time period, the prior authorization request will only cover the provider/supplier for whom the request was made. Any provider or supplier submitting claims for which no prior authorization request is recorded will be subject to 100 percent medical review.

20. How many trips at a time will be allowed under prior authorization?

A provisional affirmative prior authorization decision would affirm a specified number of trips within a specific amount of time. 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.

21. Is prior authorization required for the repetitive scheduled non-emergent ambulance transport?

Prior authorization for repetitive scheduled non-emergent ambulance transport is voluntary; however, if the ambulance provider/supplier elects not to submit a prior authorization request

before the fourth round trip in a 30-day period, the claim related to the repetitive scheduled non-emergent ambulance transport will be subject to a pre-payment medical review.