Prior Authorization Model of
Repetitive Scheduled Non-Emergent Ambulance Transports

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 the 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. **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.

3. **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.

4. **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.

5. **Are hospital-based ambulance providers included in this model?**

   No, hospital-based ambulance providers which are owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program are not included in this model and should not request prior authorization.

6. **Are independent ambulance suppliers included in this model?**

   Yes, independent ambulance suppliers are included in this model.

7. **When will the prior authorization of repetitive scheduled non-emergent ambulance begin?**

   The model will begin in **South Carolina**, **New Jersey** and **Pennsylvania** on December 1, 2014. This is the date that the MAC will begin accepting prior authorization requests for repetitive scheduled non-emergent ambulance transport with a date of service on or after December 15, 2014. All repetitive scheduled non-emergent ambulance transports with a date of service on or after December 15, 2014 must have completed the prior authorization process or the claims will be stopped for prepayment review.

8. **What is the definition of repetitive ambulance transport?**

   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.

9. **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.

10. **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 supplier elects not to submit a prior authorization request before the fourth round trip, the claim related to the repetitive scheduled non-emergent ambulance transport will be subject to a pre-payment medical review.

11. **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.

12. **What is a resubmitted request?**

    A resubmitted request is a request resubmitted with additional documentation after the initial prior authorization request was non-affirmed.

13. **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.

14. In what cases could an ambulance supplier or beneficiary request an expedited review?

An ambulance 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.

Expedited reviews should be indicated on the prior authorization request package. A reason for the expedited review should also be included.

15. 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.

16. Where on the claim should the unique tracking number be populated?

When submitting an electronic 837 professional claim for a prior authorized service, the unique tracking number (UTN) can be submitted in either the 2300 – Claim Information loop or 2400 – Service Line loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).

When submitting a paper CMS 1500 Claim form for a prior authorized service, 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.

17. 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. In addition, the Comprehensive Error Rate Testing contractor must review a random sample of claims for post payment review.

18. Are facilities responsible for submitting prior authorization requests?

No, the ambulance supplier is responsible for submitting the prior authorization requests.

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

Medicare Administrative Contractors will make these decisions.

20. Is prior authorization needed for beneficiaries during a covered Medicare Part A stay?

If the ambulance transport is included in the bundled Part A payment and is not billed separately to Medicare by the ambulance provider, prior authorization is not necessary.

21. Are beneficiaries in a skilled nursing facility (SNF) subject to prior authorization?

Beneficiaries in a SNF are subject to prior authorization if the ambulance transport is not included in the bundled SNF payment and an independent ambulance supplier is providing the transport.

22. If the beneficiary's level of service changes from BLS to ALS, for example, would a new prior authorization be required?

Yes, a new prior authorization would need to be submitted.

23. 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.

24. 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.

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

An operational guide with additional details is forthcoming and will be posted to our website at http://go.cms.gov/PAAmbulance.

26. 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.

27. 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, claims will be subject to pre-payment medical review. CMS will monitor utilization patterns to ensure that suppliers of ambulance services are not routinely limiting needed services to a certain number of trips in order to avoid the prior authorization process.

28. How many ambulance suppliers can request prior authorization for one beneficiary for one time period?

Under this model, CMS allows one ambulance supplier to request prior authorization per beneficiary per time period. If the initial supplier cannot complete the total number of prior authorized transports (e.g., initial ambulance company closes or no longer services that area), the initial supplier's request is cancelled. In this situation, a subsequent ambulance 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 suppliers are providing transports to the beneficiary during the same or overlapping time period, the prior authorization request will only cover the supplier for whom the request was made. Any supplier submitting claims for which no prior authorization request is recorded will be subject to 100 percent medical review.

29. 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.

30. Are ambulance suppliers under review by a Zone Program Integrity Contractor (ZPIC) eligible to submit prior authorization requests?

No, ambulance suppliers under review by a ZPIC are not eligible to submit prior authorization requests.

31. Where can I send additional questions?

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