

Ambulances: CMS Flexibilities to Fight COVID-19

***Indicates items added or revised in the most recent update*

Since the beginning of the COVID-19 Public Health Emergency, the Trump Administration has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states; 2) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

CMS Hospital without Walls (Temporary Expansion Sites)

- During the Public Health Emergency (PHE) for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ambulance transports. During the COVID 19 PHE, ambulance transports may include any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF, community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the ESRD facility, and the beneficiary's home.

Patients Over Paperwork

- *****Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model: Effective March 29, 2020, certain claims processing requirements for the RSNAT Prior Authorization Model were paused in the model states of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia because of the COVID-19 pandemic. During the pause, RSNAT claims were not stopped for pre-payment review***

if prior authorization had not been requested by the fourth-round trip in a 30-day period. CMS (through the MACs) continued to review any prior authorization requests that were submitted.

Given the importance of prior authorization activities to CMS' program integrity efforts, CMS discontinued exercising enforcement discretion on August 3, 2020 and resumed full model operations. Following resumption of the model, the MACs will conduct postpayment review on RSNAT claims that were paid during the pause without prior authorization. CMS will work with affected providers to develop a schedule for postpayment reviews that not does significantly increase provider burden. Claims that received a provisional affirmation prior authorization review decision and were submitted with an affirmed Unique Tracking Number (UTN) will continue to be excluded from most future medical review.

- *Signature Requirements:* With respect to ambulance transports where CMS' regulations otherwise require a physician, or, in lieu of that, certain non-physician personnel, to sign and certify that the need for the non-emergency ambulance transport is medically necessary, for claims with dates of service during the COVID-19 PHE (January 27, 2020 until expiration), absent indications of potential fraud or abuse, CMS is not reviewing for compliance with such signature requirements. Suppliers and providers should document in the medical record that a signature was not able to be obtained because of COVID-19.
- *Medicare Ground Ambulance Data Collection System:* CMS is modifying the data collection period and data reporting period, as defined at 42 CFR § 414.626(a), for ground ambulance organizations (as defined at 42 CFR § 414.605) that were selected by CMS under 42 C.F.R. § 414.626(c) to collect data beginning between January 1, 2020 and December 31, 2020 (year 1) for purposes of complying with the data reporting requirements described at 42 CFR § 414.626. Under this modification, these ground ambulance organizations can select a new continuous 12-month data collection period that begins between January 1, 2021 and December 31, 2021, collect data necessary to complete the Medicare Ground Ambulance Data Collection Instrument during their selected data collection period, and submit a completed Medicare Ground Ambulance Data Collection Instrument during the data reporting period that corresponds to their selected data collection period. CMS is modifying this data collection and reporting period to increase flexibilities for ground ambulance organizations that would otherwise be required to collect data in 2020-2021 so that they can focus on their operations and patient care.

As a result of this modification, ground ambulance organizations selected for year 1 data collection and reporting will collect and report data during the same period of time that will apply to ground ambulance organizations selected by CMS under 42 C.F.R. § 414.626(c) to collect data beginning between January 1, 2021 and December 31, 2021 (year 2) for purposes of complying with the data reporting requirements described at 42 CFR § 414.626.

- *Accelerated/Advance Payments:* In order to provide additional cash flow to healthcare providers and suppliers impacted by COVID-19, CMS expanded and streamlined the Accelerated and Advance Payments Program, which provided conditional partial payments to providers and suppliers to address disruptions in claims submission and/or claims processing subject to applicable safeguards for fraud, waste and abuse. Under this program, CMS made successful payment of over \$100 billion to healthcare providers and suppliers. As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, in light of direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund. Distributions made through the Provider Relief Fund do not need to be repaid. For providers and suppliers who have received accelerated or advance payments related to the COVID-19 Public Health Emergency, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance. Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC).
- *Provider Enrollment:* CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment:
 - Waive certain screening requirements.
 - Postpone all revalidation actions.
 - Expedite any pending or new applications from providers.

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for

additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);

- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available 42 CFR § 422.562, 42 CFR § 423.562.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Additional Guidance

- The Interim Final Rules and waivers can be found at <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.