

CENTERS FOR MEDICARE & MEDICAID SERVICES
Center for Medicare and Medicaid Innovation
Special Open Door Forum:
Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport
Wednesday, October 22, 2014
1:00-2:00 pm Eastern Time
Moderator: Jill Darling

Operator: Good afternoon. My name is (Michelle), and I will be your conference facilitator today. At this time I would like to welcome everyone to the Center for Medicare and Medicaid Services Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transports special open door forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Ms. Jill Darling. Please go ahead.

Jill Darling: Thanks (Michelle). And welcome everyone to today's Special Open Door Forum. It will be about an hour long today with the Q&A at the end of the presentation today. I will hand the call over to Connie Leonard, who is the Provider Compliance Group Deputy Director. Connie.

Connie Leonard: Thank you Jill and thank you everyone for joining us today. This is our third special open door forum on the Prior Authorization of Repetitive Non-Emergent Ambulance Transport. And we are going to go through this, basically the same presentation that we went through the last two times.

However, we do have one big announcement today. And we are modifying the date for the start date for the state of South Carolina. It previously was going to begin on October 31st, 2014 with Pennsylvania and New Jersey

coming onboard December 1st for claims for date of service as of December 15th.

And we are going to start all three states on the same day. To South Carolina, we'll now start on December 1st for claims for date of service December 15th and beyond. With that I will turn it over to Angela and Jennifer to do the presentation.

Jennifer McMullen: Hello. This is Jennifer McMullen. The purpose of this model is to establish a three year Prior Authorization Process for Repetitive Scheduled Non-Emergent Ambulance Transport. And to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments to protect the Medicare Trust Fund by granting provisional affirmation for a service prior to submission of the claim.

Prior authorization is a process for which a request for provisional affirmation of coverage is submitted for review before a service is rendered to a beneficiary and before a claim is submitted for payment. Prior authorization helps ensure that applicable coverage, payments 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 ensure proper payment before the service is rendered.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10 day period or at least once per week for at least three weeks.

Repetitive ambulance services are often needed by beneficiaries receiving dialysis, wound or cancer treatment.

Who is affected? Ambulance suppliers that are not institutionally based, that provide Part B Medicare covered ambulance services, and are enrolled as an independent ambulance supplier.

Ambulance suppliers under review by a Zone Program Integrity contractor or ZPIC are not eligible to submit prior authorization requests.

Repetitive scheduled non-emergent ambulance transport claims billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction are included.

Ambulance transports not included, include all transports included in a covered Part A stay, and all transports provided by institutionally based ambulance providers.

Where this is happening is in the state of South Carolina, New Jersey, and Pennsylvania. And location is based on where the ambulance is garaged.

The following ambulance HCPCS codes are subject to prior authorization. A0425, BLS/ALS mileage. A0426, ambulance service, Advance Life Support, non-emergency transport, level 1. And A0428, ambulance services, Basic Life Support, non-emergency transport.

No prior authorization decisions will be made on any code not on this list. If a MAC receives a prior authorization request for a code not on this list, the A/B MAC will not review the request and will not issue a decision letter.

The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 C.F.R. §410.40d.

Medicare covers ambulance services, including air ambulance, fixed wing and rotary wing, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.

The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Medicare coverage policies are unchanged. Documentation requirements are also unchanged. And time frames for transports are unchanged. This model

does not create any new documentation requirements. It simply requires the information to be submitted earlier in the claims process.

Also unchanged are that the A/B MACs conduct the reviews, all Advance Beneficiary Notice policies, claim appeal rights, dual eligible coverage, and private insurance coverage.

What has changed? The ambulance supplier will know before the service is rendered whether Medicare will pay for the service. The beneficiary will also be notified before the service is rendered whether Medicare will pay for the service.

The prior authorization request should include, the beneficiary's name, Medicare Number, date of birth and gender, the certifying physician's name, National Provider Identifier, PTAN and address, the ambulance supplier's name, NPI, PTAN and address, the requestor's name and telephone number, procedure codes, submission date, the start of the 60-day period, and the state where the ambulance is garaged. Indicate if the request is an initial or resubmission review, and indicate if the request is expedited and the reason why.

Requests also need to include a physician certification statement, the number of transports requested, documentation from the medical record to support the medical necessity of repetitive scheduled non-emergent ambulance transport, information on the origin and destination of the transports, and any other relevant document as deemed necessary by the contractor to process a prior authorization request.

And you can look at the A/B MAC Web site for further information. So now I like to turn it over to Angela to continue the presentation.

Angela: Thank you Jennifer. Number of trips, 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

The ambulance supplier or the beneficiary may submit the prior authorization request. It can be mailed, faxed, submitted through the MAC provider portal when available or submitted to the esMD system.

Review Timeframes. The initial request is the first prior authorization request for any 60 day period. The MAC makes every effort to review requests and postmark decision letters within 10 business days.

Resubmitted requests, the request submitted with additional documentation after the initial prior authorization request was non-affirmed. The MAC makes every effort to review requests and postmark decision letters within 20 business days.

Expedited circumstances are when the standard timeframe could jeopardize the life or health of the beneficiary; however, under this model this should be extremely rare, since this is only for non-emergent services. The MAC will make reasonable efforts to communicate a decision within 2 business days.

Decision letters are sent to the ambulance supplier and the beneficiary. Decision letters include the prior authorization unique tracking number that must be submitted on the claim. Decision letters that do not affirm the prior authorization request will provide a detailed written explanation outlining which specific policy requirements was not met.

The unique tracking number listed on the decision letter must be submitted on the claims. When submitting an electronic 837 professional claim, the unique tracking number can be submitted in either the 2300 Claim Information loop or 2400 Service Line loop in the Prior Authorization reference segment where REF01 equals G1 qualifier and REF02 equals UTN.

When submitting a paper CMS 1500 Claim form, the unique tracking number must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.

When a prior authorization request is submitted but non-affirmed, a submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request or provide service and submit a claim. The claim will be denied but all appeal rights are available.

For non-affirmed prior authorization requests, unlimited resubmissions are allowed. These requests are not considered appeals, however, for denied claims, all normal appeal rights apply.

What happens if you don't use the prior authorization process? If you have not requested prior authorization before the fourth round trip, the subsequent claims will be stopped for prepayment review. The MAC sends Additional Request letter and waits 45 days for a response, the MAC then reviews submitted documentation within 60 days.

Without a prior authorization decision, the supplier or the beneficiary will not know whether Medicare will pay for the service and the supplier or beneficiary may be financially liable. CMS strongly encourages ambulance suppliers to use the Medicare prior authorization process.

This next slide summarizes the different scenarios that can occur. Scenario one, the prior authorization request is submitted, the MAC decision is affirmative. The supplier can render service, submit the claim and the MAC will pay the claim as long as all other requirements are met.

Scenario two, the prior authorization request is submitted, the MAC decision is non-affirmative. The supplier can then A, render the service, submit the claim, the MAC will deny the claim or B, fix and resubmit a prior authorization request.

Scenario three, the prior authorization request is not submitted, therefore there is no MAC decision. The supplier can choose to render the service, submit a claim and the MAC will stop that claim for pre-payment review.

As for the beneficiary impact, the service benefit is not changing. Beneficiaries will receive a notification of the decision about their prior authorization request. Dual eligible coverage is not changing. Private insurance coverage is not changing.

The MACs have additional information on ambulance services on their Web site.

New Jersey and Pennsylvania, you are in jurisdiction JL, Novitas. South Carolina, you are jurisdiction JL, Palmetto GBA.

Additionally we have the model Web site, the address is <http://go.cms.gov/PAAmbulance> PAAmbulance is all one word and the PA and A in ambulance needs to be capitalized. You can find here Fact Sheets, Frequently Asked Questions, Background Information, Information on Open Door Forums, including the slides for today's presentation, and Coming Soon an Operational Guide.

You can also e-mail your questions to the Prior Authorization team at AmbulancePA@cms.hhs.gov. Now I'll pass it back over to Connie Leonard.

Connie Leonard: Thank you. And I'll mention one more time for those that may have entered the call late, so the big change that we have now said at the beginning of the open door forum was that for the state of South Carolina, the start date will now be December 1st. So all three states, South Carolina, Pennsylvania and New Jersey will now begin on December 1st for claims for date of service on or after December 15th, 2014. We extended the date for South Carolina to allow CMS and the MAC to have additional time to conduct education. I know there is some educational effort in the state of Carolina this week that were cancelled, they were cancelled because of the postponement of the date and they will be rescheduled prior to the December 1st start date.

One of the questions that we get asked often is will there be a form or a cover sheet that suppliers can use to submit the prior authorization request? And

there will be not a required CMS form but the MACs are highly encouraging suppliers to use a form or cover sheet that they have created and will be available on their Web sites in the near future, prior to the December 1st start date.

CMS also recommends the suppliers use this form or cover sheet. This form or covers sheet can not be the only thing that's submitted but it will certainly help suppliers to ensure that they submit all the required documentation which will allow for an easier and quicker approval of the prior authorization request.

And with that we like to open it up for the Q&A session.

Operator: OK, if anybody would like to ask questions, please press star one on your telephone keypad. That would be star one on your telephone keypad.

Your first question comes from Abby Wilson from American Medical. Your line is open.

Abby Wilson: Hi. Thank you. I was on Novitas Web site trying to locate the prior (authorization stacks) form and I just want to confirm that the form available on that Web site is the form we should be using to submit a request for a prior authorization.

Connie Leonard: I am not sure if that form has been uploaded to Novitas Web site yet. We certainly will confirm with Novitas and if it's not update and it's not readily available to suppliers, we'll make sure it's available so that you can see. I would suggest, you can certainly e-mail our box at the address that Angela gave, the PAAmbulance@cms.hhs.gov. Is that right Angela?

Angela: That's AmbulancePA.

Connie Leonard: I'm sorry, I had it backwards. AmbulancePA@cms.hhs.gov. To confirm that that is the correct link for the form or you can also call Novitas' customer service line.

Abby Wilson: Thank you.

Operator: And your next question comes from Noreen Scott from Pacific Medical Data.
Your line is open.

Noreen Scott: Hello.

Connie Leonard: Hello.

Noreen Scott: Can you hear me?

Connie Leonard: Yes.

Noreen Scott: Hi. My question is, I notice that you mentioned these three states and also in the invite it says three states, does this affect California or Colorado in anyway?

Connie Leonard: It does not affect California or Colorado. It is only in South Carolina, Pennsylvania, and New Jersey.

Noreen Scott: So then it will never affect us or is it just for now it won't affect us?

Connie Leonard: I don't want to say never but there are no plans, at least as of today and right now for the immediate future affects those states.

Noreen Scott: OK. Well that's all I needed to know. And thank you so much.

Connie Leonard: Thank you.

Noreen Scott: Bye bye.

Operator: Your next question comes from Priseilla Rios from AeroMedics. Your line is open.

Priseilla Rios: Hi. Yes. I'm just wanting to know where we can obtain the PDF version of the slides today?

Female: Later today.

Connie Leonard: Later today the slides will be up on the CMS prior authorization Web site.

Female: Yes.

Priseilla Rios: OK.

Connie Leonard: Do you have that Web site Angela?

Angela: Again it's <http://go.cms.gov/PAAmbulance>. And because of the short link, the PA and the A in ambulance have to be capitalized or it won't let take you there.

Priseilla Rios: OK. Thank you so much.

Connie Leonard: Thank you.

Operator: Your next question comes from Joe Scialdone, from Escambia County EMS. Your line is open.

Joe Scialdone: My question was previously answered by another caller. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Kate Kraemer from American Life Ambulance. Your line is open.

Kate Kraemer: Hi. I have a question about who should be getting the authorization. We are a dialysis transport only company. And I'm totally (slow mixed) as to why we are responsible for getting this. The ordering physician should be the one getting this authorization, calling the ambulance company with an authorization number and then we move forward with transport. We do not diagnose patients.

Connie Leonard: You're absolutely correct. And CMS is not changing the coverage determinations that still must occur by the physician. But in Medicare, the payment for the ambulance services is going to the ambulance supplier in the ambulance company. And so that is why CMS has (designated) and always has whenever there is documentation needed for that payment of that transporter comes to a supplier, it is the supplier's responsibility to get the information from the physician.

In Medicare, we always go back to whoever is receiving the payments and in this case it is the ambulance supplier.

Kate Kraemer: That could be a part of...

Connie Leonard: Correct.

Kate Kraemer: ... a huge problem, because doctors are not willing to fill up that paper work. We have been – that's for seven years, fighting to get that kind of paper work. And is anybody communicating to the doctor that this is what they need to be doing, to support...

Connie Leonard: We are -- We're doing several things to try to reach out to the physician community and you are not alone, that is an issue that CMS does here in a regular basis. It is difficult for suppliers, DME suppliers, that are types of suppliers, they relay on the physician order and that physician to get the information.

We do have a physician letter that will be available through those of the Novitas and Palmetto's Web site that you will be able to print out and share with the physician to show them what information you need and why you need it. We did find that very helpful with the power mobility device prior authorization demonstration, if suppliers had an actual letter on CMS letterhead that they could give to the physician; it did help for the physician to actually get the information.

Kate Kraemer: So we work proactively – we did that ourselves and got serious feedback from just about every dialysis unit and every primary care physician that they were not willing to take the time to write that letter up, stipulating the physical and mental condition of that patient that required that they be on a stretcher to dialysis. And I just find it unacceptable because it's going to put companies out of business.

Connie Leonard: We do appreciate your comment, but the documentation requirements are not changing, we are just getting them earlier. The physician should always have to sign if physician certification statement, they have always. It is always

been the responsibility as a supplier to get those documentation. And I do realize that you have not been able to get it and that it's been very difficult and I would respect that you've had difficulty when you've been audited in the past.

But this the project in this type of pilot that we are going to work to get the physicians to provide the documentation.

Kate Kraemer: Yes.

Connie Leonard: So I would suggest when you attend some of the educational efforts that the MACs put on, that you specifically ask, you know, what type of that – what are they doing to physicians. So try to get the word out that this is not something the suppliers can do on their own but that it is something that we need the physicians too.

We here in CMS are reaching out to the National Physician Association to get their feedback, as well as some of the Ambulance Associations. And actually one of the reasons why we are doing the letter is just feedback that we have received from the Ambulance Association.

So we do understand that this does provide some level of difficulty for the suppliers but just the way that Medicare makes payment, it requires the record to be at the supplier location and not the physician.

Kate Kraemer: I will just be very open and say we have two patients right now who can't get transportation and they will probably suffer consequences. So just – we need to really make a concerted effort. I know the AAP is reaching out but it – all they want to do is send you a history. And a history does not cover it, because then we have to diagnose the patient. We can't diagnose the patient. We are not allowed by law. So...

Connie Leonard: That is correct.

Kate Kraemer: ... it's just very difficult and I really think that it boils down the patient safety and that's where we're going to with this. And the patients are the ones who are going to suffer.

Connie Leonard: I would...

Kate Kraemer: Go ahead.

Connie Leonard: Using the letter that we're going to have out in our Web site and if you continue to have, you know, further issues and I would suggest to contact CMS through the Web site and we'll see if there's individual education that we need to do if there are particular physicians that are causing you issues.

Kate Kraemer: I think it needs to be stipulated that it is not the responsibility of an unlicensed person to diagnose the patient. And if the doctors must, if they want transportation with – the patients don't call us, the doctor calls, the dialysis center calls.

Connie Leonard: You're correct.

Kate Kraemer: And say, "Can you take an ambulance?" And OK, give us the documentation. Well here's their history. OK, here's the medical necessity. The medical necessity don't cover it. We found that out the hard way. Medical necessity don't cover it. And...

Connie Leonard: We do appreciate your comments and we do understand but for today we do need to get on some of the next questions, questions that are about this pilot as the rules are not changing from a documentation perspective. We'll be more than happy to engage in an individual dialogue here, contact our mail box. Thank you.

Kate Kraemer: Yes.

Operator: Your next question comes from Cody Wise from Ontime Transport. Your line is open.

Cody Wise: I actually have two questions. For patients who go to dialysis and wound care on 15 days or even days, do we need to make two different formal request for that transport? And also as far as the medical records, is there one particular portion of the medical record you would like or should we just send everything we have?

Connie Leonard: As far as your question, the prior authorization has approved for up to 80 round trips in a 60 day period. So it can be for both – 40 round trips, I'm sorry, I was thinking 80 trips. They are 40 round trips in 60 day period. So they can be for dialysis and wound care. You just can't exceed that 40 round trip for you. You need to come back in for another prior authorization request.

For your second question, is about to what document is included. I'd really pay attention to what's out on the Web site of Novitas and Palmetto. I believe it's Novitas that actually has a local coverage determination for ambulance. And in that local coverage determination, it does detail the specific documentation that's necessary.

As far as Palmetto, they just refer back to the Medicare coverage and benefit policy manuals. I would really review what they have on their Web site for ambulance. And if you attended any of education efforts, specifically ask the MAC specially, what are you going to be looking for? What parts of the medical record are we going to need to provide?

Operator: Your next question comes from Tricia Thigten from MedOne Medical (Tran). Your line is open.

Tricia Thigten: Does prior authorization apply to Care Improvement Plus?

Connie Leonard: Is Care Improvement Plus like a manage care organization?

Tricia Thigten: Could you say that again please?

Connie Leonard: Is that a manage care organization or is that a special demonstration? I'm sorry, I'm not familiar with that.

Tricia Thigten: Well Care Improvement Plus is a Medicare program that some dialysis patients have and move up Medicare. But it's not a replacement, it's not private though.

Connie Leonard: Let us look in to that further. And if you wanted to send in a question to the mail box, it's AmbulancePA...

Tricia Thigten: I already have. I haven't received any answer.

Connie Leonard: Angela and Jennifer are telling me that they have received the question in the mailbox. We will definitely – we have to research that and look into Care Improvement Plus, so we will definitely get you an answer back. As well as we'll make up a Q&A for our Web site for others that might be interested. Thank you for the question.

Tricia Thigten: Thank you.

Operator: Your next question comes from Scott Lesiak from Medshore Ambulance. Your line is open.

Scott Lesiak: Yes. My question is on the patient is the same location or different locations? OK, for dialysis patient, we're being required to go to, say the hospital for an X-ray. Would we need to get a prior authorization for the X-ray trip?

Connie Leonard: The prior authorization request is, it covers any transports that are medically necessary up to the 40 round trips in a 60 day period. So either it's dialysis or it's wound care or if it's transport for an X-ray, if it's something that is payable under the Medicare coverage guidelines, then it would fall under the 40 round trips in a 60 day period. You would not have to get a separate request.

Scott Lesiak: Thank you.

Connie Leonard: Thank you. And I'll just remind everyone that the prior authorization request is not required until you hit that fourth repetitive scheduled of ambulance transport within the 10 day period.

So if it's just a one time, it translates not something that you will need to get prior authorization request for.

Operator: Your next question comes from Malcolm Cameron from AmeriCare Medical, your line is open.

Malcolm Cameron: Yes. So one I would like to the timing of the certificate of medical necessity that comes from the doctors has been a struggle in getting them to appropriately and then in a good timeframe, return those forms to signed. But

in the event that there is a timing issue with getting that information from the physicians and you said this needs to be in before the 4th transport of a client. Was that properly – was that what I properly heard by that?

Connie Leonard: Yes, that is correct. The prior – the system – the claim processing system will begin to look for a prior authorization request forms. You need tracking number for that beneficiary beginning with the fourth round trip and in that 10 day period. If there is not one, that claim will not be denied but it will be stopped for pre-payment review.

So obviously it's going to be important for us to try to work with their physicians to get a completed and accurate physician certification statement.

Malcolm Cameron: OK, and then also I did see some point that the initial authorizations will be handed out in which timeframe? In two week or two week period for the initials?

Connie Leonard: The initial submission at the Medicare administrative contractors will issue a response within 10 business days.

Malcolm Cameron: And then every subsequent ones afterwards would be in what timeframe?

Connie Leonard: So how it works is you will submit one and then MAC will get back to you within 10 days. If it is affirmed, then you are good to go for the next 60 days. And then at day 45 or some point down the road, you would want to supply a new one for the next 60 days, then that would also be – decision would be made within 10 days. So it's...

It's no difference. The only difference comes then is if you get – if you submit an initial request and it is not affirmed. Additional documentation is needed for example. Then when that resubmission came in the MAC actually has up to 20 days to get a response back.

So it is very important for suppliers to try to get all the information in on the first submission because you will get a quicker response back.

Malcolm Cameron: OK. Well, I will just check, to go on record that this is a lot of pressure on the supplier end, because it's not in our hands. It's actually in the hands of the physicians and everyone else that we have to adhere to. I hope this goes as seemly says as initially planned.

Connie Leonard: Well, we do understand the information and we are still open. If any of – anyone on the phone, any of you suppliers, if you have ideas about additional educational efforts that CMS could give for physicians, we certainly understand and will also have them in our Web site.

We are trying to reach out to the physician groups and the medical associations and we do know that this is a problem not just in the EMS community. So it is something that we will be watching throughout this pilot, to one, make sure it doesn't impact suppliers. We intended to not put suppliers that (inaudible) and make sure we're not affecting beneficiary access to care.

Malcolm Cameron: OK.

Connie Leonard: Thank you.

Operator: Your next question comes from Shirley Mole from Personal Care Ambulance. Your line is open.

Shirley Mole: Yes, thank you. My question was can you be more specific regarding the medical documents that you are requiring. For instance, we transport patient from their resident. Would that come from their primary physician or from a dialysis planning itself?

Connie Leonard: The medical documentation is going to be necessary for the transport were not coming from the dialysis center; it's going to come from the physician that ordered the dialysis and ordered the transport. So your physician that's signing that physician certification statement is where the data that you need to get the documentation to support medical necessity of the transport.

I would suggest that you attend one of the educational sessions by the MAC and make sure you ask them for specifics. They are the ones that are going to

be reviewing the claims. So they're going to be able to give you details and examples as to what they look for and what they're looking for, you know, with these types of records.

So as they get scheduled in the next six weeks, I certainly would suggest that you attend. As you know that, you know, they're planning on sites and also webinar and conference calls, so that should be a medium that everybody should be able to at least get to one of these educational sessions, so just hear from the MAC and to be able to ask questions.

Shirley Mole: Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Neal Blanton from First Choice Ambulance. Your line is open.

Neal Blanton: Yes, I was just wondering if is there like a test period to the pilot where we can, you know, go ahead and start submitting them, to make sure we're doing it right and getting the proper pay for it?

Connie Leonard: There is not a test period per se but that time period from December 1st to December 15th, it does allow suppliers to go ahead and submit that documentation. For those beneficiaries that or one that has been scheduled ambulance transport as of that time, for December 15th and beyond.

And so that does allow this two week period that is somewhat like a test or to make sure that you're starting to send in the documentation in advance so that when it actually becomes effective in December 15, the suppliers and the MAC are not overrun with all of these requests.

So I would highly encourage suppliers to use that time period from December 1st to December 15th. Just kind of work with the MAC and make sure you're getting your documentation in.

Neal Blanton: OK. So we're not submitting any prior authorizations until December 1st?

Connie Leonard: Until December 1st, correct. And even when you submit them on December 1st, it's going to be for date of service December 15th and beyond.

Neal Blanton: OK. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Melissa Wall from MetraHealth Care. Your line is open.

Melissa Wall: Hi, good afternoon. I believe you answered my question previously but just to reconfirm, the prior auth., it's not required for Michigan yet, correct?

Connie Leonard: That is correct. Michigan is not included.

Melissa Wall: OK. Thank you.

Operator: Your next question comes from Michelle Zapata from Golden Hour. Your line is open.

Michelle Zapata: Good morning. I just wanted to clarify that the hospital based ambulance transports are not included in this and that you are determining that if they're hospital based by the base or their ambulance is stored – kept.

Connie Leonard: That is correct. Hospital based ambulances, if you are owned by a hospital; you are not included in this model, only independent ambulance transport service companies that are included.

Michelle Zapata: Perfect, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Don Hosey from Clarion Hospital. Your line is open.

Don Hosey: Hi. This is Don at Clarion. I guess the previous caller just answered or asked the same question where hospital based service in Pennsylvania, so I guess we're excluded from the program, is that correct?

Connie Leonard: That is correct. If you're a hospital based company, you are excluded from the model.

Don Hosey: OK. Thank you so much.

Connie Leonard: Thank you.

Operator: Your next question comes from Josh Watts from MedTrust Medical. Your line is open.

Josh Watts: Yes. Good afternoon. Over the last 60 days since this information first came out. We had quite a bit of conversation with both the dialysis – major dialysis clinics as well as the nephrologist themselves. And one issue that they brought up is that the PCS signing physician often does not see the patient within the first 10 days. Their nurse practitioner may but depending on their rounding schedule at the clinics, they may not actually physically lay eyes on the patient, until after this required timeframe.

So in operation, none of the nephrologists were aware of the change until brought it to their attention, and at this point, none of them has been asked to participate in any additional education regarding this. And that's a real concern that they have and I didn't know if that was something specifically that you guys had addressed or thought off yet.

Connie Leonard: No, that – Thank you. That's a very good point that we should try to reach out to different associations, from dialysis centers and nephrologist associations to make sure that one they're aware that this is happening until just to again and for the importance of them providing this timely documentation.

So we will certainly take that under consideration and see what we can do with the MAC to make sure that they're also reaching out to that particular audience in the three states.

Josh Watts: Right. And the back part of that we've had a lot of pushback with the request to sign this document well ahead of the covered transport date. We're being told that they don't want to make a diagnosis of patient condition three weeks

from now and that's basically what we're going to be asking then to do in order to submit this document prior to the, I guess the first 60 day period...

Connie Leonard: We have that – I totally agree that they should not be signing the documents even three weeks in advance. We have actually had this conversation with both of the MACs and a physician certification statement that is signed and currently in a 60 day period physician certification statement. I believe it's typically valid for 60 days as long as it's within that 60-day type period, the MAC will accept that and move forward...

Josh Watts: Right.

Connie Leonard: ... with your current PCS. And then when it's – when that one expires and gets the new one, that one will be used for the next 60 day round. So we are not asking any of them to forward date a PCS, so that you have the same 60 day time period. We do realize that beneficiaries are receiving this treatment today and that they have a valid PCS on file today and you would just use your valid PCS that you had today. You would not need a new one to start the process.

Josh Watts: Right. No, I guess that's...

Yes, it's a different scenario I'm talking about. So...

Connie Leonard: I'm sorry.

Josh Watts: That's OK. If we've already had a patient with a prior authorization and you've asked us to turn in another one, give them the MAC 10 business days to issue that PA number for us to bill against. We are asking the doctor to sign the PCS, 15 days prior to the transport date. That's where they pushing back.

Connie Leonard: I see. So just from a recurring perspective...

Josh Watts: Right. There's...

Connie Leonard: They don't want to certify that the patient is still going to need the transport in 10 or 15 business days in advance.

Josh Watts: Correct.

Connie Leonard: That is something that we will talk with the MAC about and we'll make sure that we get some detailed Q&As that you have. We want to handle that situation. I certainly – now I understand what you're saying. Thank you for taking the time to explain it a little bit better for me.

Josh Watts: All right. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Karen Barnes from VitalCare EMS. Your line is open.

Karen Barnes: Yes. My question is about the PTAN that you're requesting from the physician. Now, is that from the physician that's signing it? Is it from the nephrologist office? And how do I go about getting the PTAN?

Connie Leonard: It's going to be the PTAN for the physician that's signing, the physician certification statement. And we do realize that this is a new piece of information that they are not used to giving you.

My suggestion to suppliers and I know – I obviously – I felt the frustration that you guys have today regarding getting the documentation from the physician. But when you get in this and you tell them that you need to get the certification statement. I would also share with them the form or cover sheet from the MAC and, you know, highlight, you know, this is what we need from the physician's office, or we will not be able to submit this prior authorization request.

So the PTAN was a number. That number was one that the MAC felt was vital for their timely processing of the prior authorization request. It is something that they will have on their form that will be posted to their Web site. So I would share that form cover sheet with the physician's office to say this is exactly what we need to be able to submit this for your beneficiary.

Karen Barnes: What is going to happen if they refuse to give that to us?

Connie Leonard: I would suggest – ask the MAC that question. I do not believe in the beginning they will deny just say from lack of a PTAN, but I do believe that they're going to want to see comparable effort that you try to get it and to suggest some calls between your office staff and the physician's office staff. It certainly should be a number that the physician's office staff knows. It is not something that just the physician is going to know.

In our conversations with MACs though, this is not necessarily one of those topics they would deny it for in the beginning but it is a number that they felt was very important but though we understand that this is going to – there is going to be a transition time for everyone in the beginning as a new practice and a new procedure. So don't expect to see being denied in the beginning but we do want this to be a number that they're overtime starting to provide to us.

Karen Barnes: Thank you.

Operator: Your next question comes from Timothy Pitko from Personal Care Ambulance. Your line is open.

Timothy Pitko: Hi, good afternoon. I have a – is anybody there?

Connie Leonard: Yes, hello.

Timothy Pitko: OK. I have a couple of questions real quick. Do you know the dates for South Carolina for training? I know they are canceled but I didn't catch ...

Connie Leonard: We have not release the rescheduled dates yet, but I would continue checking Palmetto's Web site. They will be rescheduling their training.

Timothy Pitko: OK. Another question is, and we've been running into this problem with the dialysis directors and so forth that are saying that this is our responsibility now to get the medical necessities form, it's not their responsibility. Is there going to be a continuing education for these, because a caller earlier stated that pretty clearly about the prior authorization we can't diagnose. So if there's something in the works that could possibility educate them to, you

know, we can't transport that qualified patient without your signatures and your review of the patient.

Connie Leonard: Yes. We will certainly work with the MAC to ensure – to determine what is the best place to reach out to these dialysis centers to ensure that they are providing you a the physician is providing you what all the necessary information you need.

We certainly have tried to reach the physicians. I know the MACs have been trying to reach all affected parties but we will ensure that they're reaching out to the dialysis centers and we will also work to reach out to the National Dialysis Association just to make sure that everyone is aware that this is happening and to see if we can get on one of their calls, one of their news letters to make sure that again, this is something that everyone needs to be a part of. Every – when we talk to the associations, they – everyone thinks to say this is a good idea in theory. We need everyone's, I guess, collaboration to make it supportive and at the end of the day, this is a good thing.

It's good to know that the transports are covered and two, that your payments – you're not going to have to worry about that payment being taken back down the road. But that – this will take everyone's cooperation and we will work to make sure that we're reaching out to this entities too.

Timothy Pitko: And I agree with that, but I have a couple – hello?

Connie Leonard: Go ahead. Take your time.

Timothy Pitko: Just a scenario here because this hasn't been mentioned but just for example say a patient was discharged from the hospital now to either home or to nursing home and we need dialysis the next day that meets what we feel the requirements to go to dialysis. And we know upfront that it's going to be a repetitive transport right then and there. How does that prior authorization work when the patient needs to go less than 24 hours later to dialysis under Medicare with the submission – with the prior authorization? It's like – then you'll say it's denied for some reason and we've done 10 transports for this patient with what we had saying that it meets the requirements.

Where does that the – so 10 days of – good amount of transport if you're doing round trip into dialysis during that timeframe to get approval. The new patients, where do you all stand on that?

Connie Leonard: You're right, 10 days –certainly three or four trips may occur in that 10 day period. And so the system, the claim reference system is not going to be looking for that firm's prior authorization until that fourth round trip. So if someone is discharged from the hospital, they need dialysis the next day, you can transport that beneficiary. And then at that time, as soon as you get the order request, you're going to start working on getting on the required documentation so that you can submit it.

If there's not unique tracking number after this fourth round trip, the system is not going to deny claims. All they will do is just stop them for pre-payment review. The pre-payment review just means that medical records are going to be requested prior to the claim being paid.

So here is the situation, before the information gets in, you may decide to hold your claims and then you'll submit them after the request is affirmed so they won't be stopped for pre-payment review.

If it's a beneficiary that you know, is going to need dialysis and physician or the documentation is there, even if a non-affirmative decision comes in when you – you can resubmit that prior authorization request multiple times to ensure that you get the necessary documentation. Any claims that come in aren't going to be – necessarily be denied but they will be stopped for pre-payment review.

And so it's going to be very important and we realize in the beginning there is going to be a learning curve that we could see either lots of resubmissions that additional documentation is necessary. We do hold back for the first couple of months. Everyone will get more familiar with what's required and the process will go a lot smoother.

So we certainly do not want suppliers not transporting the beneficiaries that need the care. It's kind of why we added then that fourth – it's not looking for until that fourth round trip.

Timothy Pitko: Correct, but that kind of puts the providers under the gun because in that sense because the – if you had a new dialysis patients that you've affirmed that you believe that will need the requirements that it's not kicking in to the fourth transport or, you know, repetitive transport. Then we've already – and for some reason it's being denied or totally denied and all that matters it just puts the, you know, it get back on the ambulance provider shoulders instead of the how can maybe the hospitals or dialysis centers. They pretty much know they're going to need this upfront and do the prior authorization while they're still in the hospital or – you see where I'm coming with that?

Connie Leonard: I do and I do understand that, you know, the burden for submitting the documentation to the supplier and I do understand that everyone, you know, has stated several times not just to say but several times to us. But you know, unfortunately, that is the way the Medicare is set up. The payment goes to the supplier, so the supplier is the one that is responsible.

And, you know, we want to work with the suppliers. We want to work with the physicians to get you the necessary information.

And so, I'm very interested to hear a lot of you today say that the physician certification statement takes longer than 10 days to this way, and so, you know, one of our goals needs to be, how can we get that feedback quicker? What type of documentation do we need to get to physicians? What do we need to do to make sure they're providing you guys with the necessary information quicker?

And so it's certainly – we will take back one of our action items to make sure we're reaching out to all necessary parties to try to assist as much as we can. And as we move forward, I mentioned earlier and I'll mention again, you know, if there are particular physicians or dialysis centers that you just can not get information from, you know, that is something that we would want to know and we'll be willing to work with the MAC to provide them with individual education if need be.

They do have a responsibility to the Medicare program just to provide that information.

Timothy Pitko: Correct. And that it's happening currently in Charleston, South Carolina with some of the – not facilities, I'll not name in any of them but they currently are saying that this is our responsibility to get the appropriate information.

But I just wanted to expand upon one other question that was asked earlier about the documentation. If there is some kind of like check list of items, we could go down because the documentation broad spectrum for their medical records.

They can, you know, have too much or not enough but we would like to know exactly that we could check off each individual item that if we've got (CMN checked) – yes, we got – where the doctor says this patient is non-ambulatory bed bound and everything else. Is there something at the check list that Jill could provide or put on your Web site that each provider could have to know exactly what they need to send and to submit in order for it to be approved or denied?

Connie Leonard: Here in South Carolina, it's the Palmetto will have a form or a cover sheet or check list or whatever, you know, we want to call it. So they will have something for providers to use. So well it's not mandatory, they are highly encouraging suppliers to use it. I believe you guys will – it sounds like everybody wants to have some type of form or check list. So Palmetto does have one. I do not know if it's on their Web site but we will certainly find out and make sure if it's not, that it gets up there soon.

Timothy Pitko: OK. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from Jason Lowder – excuse me – from East Palmetto Ambulance. Your line is open.

Jason Lowder: Hey, how are you all?

Connie Leonard: Hello.

Jason Lowder: All right. I know there's a bunch of questions and my brain is kind of scrambled, so I'm going to be unorthodox asking questions kind of here and there.

Connie Leonard: Go right ahead.

Jason Lowder: I guess the first one is the supplier is responsible for the prior authorization, correct?

Connie Leonard: That is correct.

Jason Lowder: All right. So that would mean if we had a second party billing company did our billing for us, they wouldn't be responsible for that, right? If we didn't do our own in-house building, we actually contracted someone to do our billing for us.

Connie Leonard: So that building company also housed your medical records and your physician specifications statements from things that you have today or do you keep that in-house?

Jason Lowder: Both, we actually – they get copies of that as well because they do our submissions for us for Medicare.

Connie Leonard: I got you. And I'm going to give you an answer but I'm going to qualify to say that we will double check for you and make sure that, you know, we get back to you if you want to e-mail the Web site or we can do a Q&A. If you use a third party biller that is a supplier's right to use up their billing company and you are certainly willing – you can have them submit the prior authorization request on your behalf. That's perfectly fine, just to say submit the Medicare claim on your behalf.

Again, you obviously want to work with them and make sure they know the requirements have to be submitted. But I believe that they can submit it for you. I do want to get clarification on that but I feel pretty comfortable to say that if – that is a supplier's right to use a billing company and the billing company can certainly provide medical records to CMS and they do it other times.

Jason Lowder: OK. Next would be and that was the other question, is how do exactly do we submit? Do we do it by products? So we could do it by both electronic and fax and all of that implication.

Connie Leonard: There are three – yes, there are three ways and I actually think there's going to be four ways that you can submit the prior authorization request. You can mail it and that's obviously the slowest, and we don't expect many will do that. You can send it by fax and that Palmetto we'll have a fax number that providers can use.

You can also use esMD or the Electronic Submission of Medical Documentation. Both Novitas and Palmetto will accept prior authorization requests through that. And I believe maybe not right away but certainly shortly after both Palmetto and Novitas will use of their provider portals for these submission of a prior authorization request.

That last one. That portal, that's probably a question for the MAC, some of their educational events, but the first three mail, fax and esMD are definite alternatives to providers and users to submit a request.

Jason Lowder: OK. So regardless to how we get prior authorization or submit for, it will be in a letter form, the prior authorization number or how we would get – we would get that back by mail, correct?

Connie Leonard: You will get back – you will get your authorization back by mail and if you would like, we had given the MACs permission to use that as long as the supplier has agreed that they want it by fax, or the use of their portal.

We can not as of today send back a response via esMD. We should be able to shortly after the beginning of the calendar year, maybe in the March timeframe, we can not yet but they will do fax or potentially those portals if suppliers request.

Jason Lowder: OK. And the other thing is if we do it prior for prior authorization, the submission date that will be – the submission date will be what was actually

on you guy's cover sheet and the PC in or the physician's form, that the submission date will be on the top of those.

So you say we're trying to get a prior authorization for a patient just to say for tomorrow, OK? And we see in the paperwork in. Of course we got 10 days or just before the fourth trip to actually get that prior authorization number. But do we put it on there as just to say October the 22nd, that will be the submission date so it will go back to the 22nd and 60 days forward from that time period?

Connie Leonard: It will be 60 days from your requested start date. So if you requested to start on you know, December 20th, I don't know. Then it would be 60 days from that particular point in time.

Jason Lowder: OK. All right. And the other was on the prior authorization request content, on the continue page, page 13, it says numbers of transport is requested. We don't have to put in a number of transports requested because you guys are going to allow us up to 80 round trips, correct?

Connie Leonard: That is correct. It is going to be up to 80, but if you have someone, you know, that's going to get a wound care and they only need to make 20 round trips just something like that, if it's a number that's less than 80, you could fill it in. If it is blank, then they will also approve it up to 80.

Jason Lowder: So in this is hypothetical, I think somebody asked earlier but just to make sure if somebody who is on dialysis is receiving wound care treatments or chemotherapy radiation and it still does not exceed to 80 round trips, can we just leave that one prior authorization for that one patient up to that 80 trips?

Connie Leonard: That is correct.

Jason Lowder: OK. All right. And then the other question that I had was the PTAN and the NPI numbers, I think about someone asked this question earlier, she said what if they refuse to give it to us? If they were to give it to us or the staff would be able to supply us with that information, can we just keep that on file and we don't continue to ask for it each 60 days for prreauthorization?

Connie Leonard: Absolutely. I would suspect that you're going to have – you have physicians that you guys work with on a regular basis. Some of this information you are going to start, if you had that record of.

Jason Lowder: As of December the 1st, OK, or before or by December 15, if they were to refuse and what if the staff would be told not to give it to us and these guys aren't educated enough on knowing that we need this information for prior authorization, will we have a grace period for that until these guys know what they need to know or you guys hoping to have all these done before then?

Connie Leonard: Well, if you do have a situation where a physician is not willing to give you his information, I would certainly make a note of that on your form when you submit it to the MAC if you were unable to get this information from the physician.

So there should be no reason for them not to give out their NPIs that actually is public information that anyone can get. So if that is as an issue, then I would just make a note on the forum check list that you submit to the MAC.

Jason Lowder: OK. And then I think – two more things, next one will be up on the...

Connie Leonard: We are actually are out of time. Could you send in your additional questions to the mailbox and we'll get right back to you?

Jason Lowder: OK. That's no problem at all.

Connie Leonard: Thank you. Thank you so much. I appreciate it. And thank you – thanks to everyone today. It's a great question.

Operator: Your next question comes from (Jay)...

Jill Darling: (Michelle) we're not taking anymore questions.

Operator: OK.

Jill Darling: And that will be end of today's special open day forum.

Connie Leonard: Thank you everyone.

Operator: So this concludes today's conference call. You may now disconnect.

END