

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model

Note: We revised the article to show that the model will not end on December 1, 2020. The model no longer has an end date and will remain in effect for the nine model states. All other information is unchanged.

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for independently enrolled Medicare ambulance suppliers who (1) provide repetitive, scheduled non-emergent ambulance transports for Medicare Fee-For-Service beneficiaries, (2) are garaged in Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, or West Virginia and (3) submit claims to Medicare Administrative Contractors (MACs) for ambulance services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) began a 3-year prior authorization model for repetitive, scheduled non-emergent ambulance transports in the states of New Jersey, Pennsylvania, and South Carolina on December 1, 2014, for transports on or after December 15, 2014, regardless of the origin or destination of the transport. Six additional areas were included in the model – Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia – on December 15, 2015, for transports on or after January 1, 2016.

The model was extended three additional years and was previously scheduled to end in all model states on December 1, 2020. However, the model no longer has an end date and will continue in effect for the nine model states.

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CMS is issuing this Special Edition (SE) 1514 solely as an educational guide to improve compliance with documentation requirements for the repetitive, scheduled non-emergent ambulance prior authorization model. SE1514 presents useful information that will help suppliers receive provisional affirmed decisions for prior authorization requests submitted for beneficiaries that meet coverage and medical necessity requirements.

See the Background and Additional Information Sections of this article for further details, and make sure that your billing staffs are aware of this information.

Background

Medicare covers ambulance services, including air ambulance (fixed wing and rotary wing) services, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The Medicare ambulance benefit for non-emergent transports is very limited and designed only for beneficiaries who are clinically unable to be transported by other means. Non-emergent transportation by ambulance is appropriate if either:

- (1) The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or
- (2) The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Therefore, bed confinement is not the sole criterion in determining the medical necessity of non-emergent ambulance transportation; rather, it is one factor that is considered in medical necessity determinations (See [42 CFR 410.40\(d\)\(1\)](#)).

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips (or six one way trips) within a 10-day period, or at least once per week for at least 3 weeks.

Repetitive transportation services are often needed by beneficiaries receiving dialysis, covered wound care, treatment interventions or cancer treatment. For wound care, it is anticipated that wound care is managed in the home and requires only periodic clinic appointments for:

- Debridement
- Wound management or
- Infection types of services.

In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health (whether or not such other transportation is actually available), no payment may be made for ambulance services. In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service **at a covered destination**, or to return from such a service.

Medicare may cover repetitive, scheduled non-emergent transportation by ambulance if:

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- (1) The medical necessity requirements described previously are met (that is, bed confinement or medically required); and
- (2) The ambulance provider/supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met.

Note: Per 42 CFR §410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished (See [42 CFR 410.40\(d\)\(2\)](#)). The written order is often referred to as a Physician Certification Statement (PCS).

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services **and requirements for ambulance suppliers** can be found in 42 CFR 410.40 and [42 CFR 410.41](#) and in the "Medicare Benefit Policy Manual", [Chapter 10](#).

Under this model, an ambulance supplier or beneficiary is encouraged to submit to their MAC a request for prior authorization along with all relevant documentation to support Medicare coverage of a repetitive scheduled non-emergent ambulance transport.

Note that prior authorization does not create new clinical documentation requirements. Instead, it requires the same information necessary to support Medicare payment, just earlier in the process.

Prior authorization allows ambulance suppliers to address issues with claims prior to rendering services and to avoid an appeal process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

Submitting a prior authorization request is voluntary. However, if prior authorization has not been requested by the fourth round trip, the claims will be stopped for pre-payment review. After receipt of all relevant documentation, the MAC will make every effort to conduct a review and postmark (or fax if a fax number is provided) the notification of their decision on a prior authorization request within 10 business days for an initial submission.

PCS and Documentation that Facilitates an Affirmative Decision

In order to be provisionally affirmed, the request for prior authorization must meet all applicable rules and policies, and any applicable Local Coverage Determination (LCD) requirements for ambulance transport claims.

- Make sure the PCS is completed for the particular beneficiary and must not be more than 60 days prior to the requested start date. Only conditions specific for the beneficiary should be noted and all applicable comments should concern the beneficiary's current condition.
- Make sure the PCS and documentation submitted is signed with a legible signature and/or there is a signature log for the clinician's signature.
- Make sure the relevant documentation sent with the prior authorization request provides a clear description of the beneficiary's current condition requiring ambulance transport. The documentation should support the beneficiary's condition at the time of transport and be dated prior to the requested start date of transports. This information must be from a clinician who provided service to the beneficiary, not the ambulance supplier.

The top reasons for non-affirmations are as follows:

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- A PCS was not submitted, was not signed, was missing credentials, was incomplete or was more than 60 days prior to the requested start date.
- Medical documentation was not submitted with the PCS.
- Medical documentation submitted did not support what was included on the PCS.
- Medical documentation submitted did not support the beneficiary's condition at the requested time of transport, did not include the beneficiary's name, or in some cases, was not legible.

Key Items to be Addressed

1. PCS

- The PCS must be signed and dated by the beneficiary's attending physician the date it is completed.
- The signature, credentials, and date must be readable.
- The prefix "Dr." is a title and not a credential.
- Stamped signatures or file signatures are not acceptable.
- The PCS cannot be dated more than 60 days in advance of the requested start date.
- The PCS information must be verifiable.
- Medical documentation must be attached that supports the PCS and that describes the beneficiary's condition(s) that necessitate(s) the type and level of ambulance transports.
- A signed and dated PCS does not, by itself, demonstrate that the repetitive scheduled transports are medically necessary.

2. Medical Documentation

- Medical documentation should provide sufficient information to support the prior authorization request form and the PCS.
- Documentation should:
 - Reveal the medical necessity of the type and level of transport services.
 - Reveal the exact origin address and destination address.
 - Specify the beneficiary, provider and date of service.
 - Capture the "what" and "why" of a beneficiary's condition(s) that necessitate(s) the transports.
 - Support the diagnoses or the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code(s) on the PCS with clinical assessment data and objective findings.
 - Be readable and support the beneficiary's condition at the time of transport and be dated prior to the requested start date of the transports. While a beneficiary may present with chronic conditions that do not change, recent medical documentation must be available to indicate chronic or progressively worsening needs.
- Documentation can include, but is not limited to:

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- Doctor's progress notes,
 - Nursing notes,
 - History and Physical Exam,
 - Physical or occupational therapy notes,
 - Home health care notes, and
 - End stage renal disease (ESRD) monthly capitation payment provider notes.
- For admission and discharge summaries for a condition itemized on the PCS, the documentation must contain statements that capture the “what” and the “why” (for example, if a beneficiary’s condition is bed-confined, documentation must indicate why the beneficiary is bed-confined).
 - The documentation should not contradict the PCS (for example, beneficiary is indicated as bed-confined on PCS, however, medical records document the beneficiary uses a wheelchair).

Example of Documentation that Identifies the “What” and the “Why”

Included in the Progress Note:

Patient is an 80 year old white male with a history of ESRD being treated with hemodialysis at ABC Dialysis Center. Wegener’s Disease, Atrial Fibrillation, severe osteoporosis, and Spinal Stenosis all treated by Dr. Smith. Recently, patient has had “bouts” of pneumonia. Patient has extremely fragile bones, to the point that any lifting of the patient even with a “Hoyer Lift” can and has resulted in dislocations and fractures. Patient has bilateral elbow flexion of 30 degrees, reduced plantar strength with a max of 1 out of 5 bilaterally and 0 degree max hip flexion bilaterally. Bilateral knee flexion is 0 degree. Patient is Alert and Oriented x4 at baseline with a GCS of 15.

Patient requires assistance in the areas of bathing, dressing, toileting and cleaning himself, transferring, unable to get up from bed, and feeding. Patient does not exercise any control over urination and defecation.

Patient is completely bed-confined. Due to contractures, weakness, and over deconditioning, patient is unable to ambulate, sit or stand. Based on the physical assessment and the physical limitations noted, the patient is on fall precautions from bed.

This patient requires stretcher for transport due to non-weight bearing, non-ambulatory, bed confined status, and patient cannot support himself for any amount of time. Monitoring is required to prevent injury or fall from stretcher.

Note: For those in Jurisdiction J-L, you may want to review Local Coverage Determination (LCD) [L35162](#) published by the MAC, Novitas Solutions, Inc.

Methods for Sending a Prior Authorization Request Package to Your MAC

Submitters have four options for submitting prior authorization requests to their MAC:

1. Fax,
2. Mail,
3. MAC Provider Portal, or

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4. Electronic Submission of Medical Documentation (esMD).

For more information about esMD, see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html> on the CMS website, or contact your MAC.

Addresses and Fax Numbers of the MACs

1. For ambulance suppliers in Jurisdiction J-L, send requests to the MAC Novitas Solutions, Inc. at:

- Fax Number: 1-877-439-5479
- Mailing Address: Novitas Solutions
Part B Prior Authorization Request
PO Box 3702
Mechanicsburg, PA 17055
or
Novitas Solutions
Attention: Part B Prior Authorization Request
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

- Electronic Submission of Medical Documentation (esMD): (indicate content type “81” or “8.1”)

2. For ambulance suppliers in Jurisdiction J-M, send requests to the MAC Palmetto GBA at:

- Fax Number: 803-462-2702
- Mailing Address: Palmetto GBA – JM MAC Prior Authorization
PO Box 100212
Columbia, SC, 29202-3212

- Electronic Submission of Medical Documentation (esMD): (indicate content type “81” or “8.1”)

Additional Information

If your patient does not qualify for Medicare transportation, there may be other state and local services that can help. Beneficiaries, case managers and care givers may contact Eldercare at 1-800-677-1116 or their local State Health Insurance Assistance Program.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

You may want to review the following educational materials on the CMS Prior Authorization Website at <http://go.cms.gov/PAAmbulance>:

- *Ambulance Prior Authorization Frequently Asked Questions (FAQs),*
- *Ambulance Prior Authorization Operational Guide,*
- *Physician/Practitioner Letter that ambulance suppliers can share with physicians and other entities to help obtain the necessary documentation in a timely manner, and*
- *Links to the participating MACs' Ambulance Prior Authorization websites.*

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Questions can also be sent to the following CMS email address: AmbulancePA@cms.hhs.gov

Document History

Date of Change	Description
November 20, 2020	We revised the article to show that the model will not end on December 1, 2020. The model no longer has an end date and will remain in effect for the nine model states. All other information is unchanged.
July 24, 2020	This article was revised to provide information on transportation for beneficiaries in the Additional Information section of this article. All other information is unchanged.
October 28, 2019	This article was revised to announce that the model has been extended an additional year and is currently scheduled to end in all model states on December 1, 2020, based on date of service. All other information is unchanged
December 20, 2018	The article was revised to provide updated information. The updates include: 1) Extending the model to end in all model States on December 1, 2019, 2) Updating the PCS and Documentation that Facilitates an Affirmative Decision Section; 3) Updating the Medical Documentation Section; 4) Updating the Medical Documentation and adding resources in the Additional Information Section. While the updates are annotated in bold, please review the article carefully for the changes.
February 14, 2018	This article was revised to provide updated information. The updates include: 1) Adding ambulance transports in Jurisdiction L: Delaware, the District of Columbia, Maryland, and Jurisdiction M: North Carolina, Virginia, or West Virginia, effective for transports on or after January 1, 2016; 2) Updating the PCS and Documentation that Facilitates an Affirmative Decision Section; 3) Updating the Medical Documentation Section; 4) Updating the Medical Documentation and adding resources in the Additional Information Section.
May 4, 2015	Initial article released

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