Spotlight on Compliance

An Overview of the Compliance Challenges Facing EMS Providers

Brian S. Werfel, Esq.

June 21, 2016
PARANOIA
That unmistakable feeling everyone is out to get you!

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Today’s ambulance providers and suppliers face the most challenging compliance environment in recent memory, certainly since the implementation of the Medicare Ambulance Fee Schedule, and most likely at any time prior to that.
Medicare Fraud Strike Force Locations
Hospital Settlement re: Non-Emergency Ambulance

• 9 hospitals in Jacksonville (FL) area have agreed to pay a total of $6.25 million to resolve allegations related to the improper use of ambulances for hospital discharges
  – 1 of 2 ambulance companies implicated has also settled

• Allegations were that the hospitals were knowingly ordering ambulances to discharge patients that could go safely by other means
  – Financial benefit was to ambulance companies
  – Intangible benefits to hospitals
Ambulance Kickbacks

• 5 ambulance companies in Southern California have agreed to pay a total of more than $11.5 million to resolve allegations related to potential kickbacks
  – Allegation was that ambulance companies engaged in “swapping” schemes to provide deeply discounted ambulance services to hospitals and nursing homes in exchange for referrals
Ambulance Kickbacks

- Regent Management Services (Galveston, TX) paid $3.2 million to resolve charges that it received free or heavily discounted ambulance transports in exchange for referrals from several ambulance companies.
CITY OF DALLAS TO PAY $2.47 MILLION TO RESOLVE ALLEGATIONS THAT IT CAUSED IMPROPER MEDICARE AND MEDICAID AMBULANCE CLAIMS

DALLAS — The City of Dallas has agreed to pay the U.S. and Texas $2.47 million and enter into certain compliance obligations to resolve allegations that it violated the civil False Claims Act and Texas Medicaid Fraud Prevention Act, announced U.S. Attorney James T. Jacks of the Northern District of Texas. The U.S. and Texas contend Dallas caused “upcoded” claims to be submitted to Medicare and Medicaid for city-dispatched 911 ambulance transports between 2006 and 2010. Dallas fully cooperated with the investigation, and by settling did not admit any wrong-doing or liability.
FOR IMMEDIATE RELEASE
TUESDAY, AUGUST 23, 2011

GOVERNMENT RECOVERS MORE THAN $1.6 MILLION FROM
ELEVEN CITIES TO RESOLVE ALLEGATIONS THEY
CAUSED IMPROPER MEDICARE AND MEDICAID AMBULANCE CLAIMS

DALLAS — The Texas cities of Plano, Frisco, Richardson, Mesquite, Celina, DeSoto, Corpus Christi, Cedar Hill, Rowlett, North Richland Hills and University Park (collectively “Cities”) have agreed to pay the U.S. and Texas the collective amount of $1.69 million to resolve allegations they violated the civil False Claims Act and Texas Medicaid Fraud Prevention Act, announced U.S. Attorney James T. Sacks of the Northern District of Texas. The U.S. and Texas contend all the Cities caused “upcoded” claims to be submitted to Medicare and Medicaid for city-dispatched 911 ambulance transports between 2006 and 2010. All the Cities fully cooperated with the investigation, and by settling, did not admit any wrongdoing or liability.

Ambulance services generally are coded either as basic life support level or advanced life support (ALS). ALS transports are reimbursed at a higher rate by both Medicare and Medicaid. The U.S. and Texas contend the Cities’ billing contractor coded 911-dispatched transports at the ALS level, which indicates an ALS service was furnished and/or the patient’s condition necessitated an ALS intervention. The U.S. and Texas
PART B PAYMENT DATA RELEASE

• On June 1, 2015, CMS released the CY 2013 Medicare Provider Utilization File
  – Sortable database of FFS payments by individual physician, ambulance supplier and other health care suppliers
## American Ambulette & Ambulance Service, Inc

**Ambulance Service Supplier**  
729 6th Street NW/A Life | Portsmouth, OH

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number performed</th>
<th>Number of Medicare patients</th>
<th>Average Medicare reimbursement per procedure</th>
<th>Total Medicare payments for procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance service, basic life support, non-emergency transport, (bls)</td>
<td>41,337</td>
<td>9,579</td>
<td>$161.41</td>
<td>$6,672,205</td>
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<tr>
<td>Ground mileage, per statute mile</td>
<td>635,388</td>
<td>14,885</td>
<td>$6.36</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance service, advanced life support, emergency transport, level 1 (als1-emergency)</td>
<td>4,632</td>
<td>3,875</td>
<td>$307.65</td>
<td>$1,425,035</td>
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<tr>
<td>Ambulance service, basic life support, emergency transport (bls-emergency)</td>
<td>5,398</td>
<td>4,209</td>
<td>$257.28</td>
<td>$1,388,797</td>
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<tr>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (als1)</td>
<td>1,410</td>
<td>1,128</td>
<td>$191.71</td>
<td>$270,311</td>
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<td>Equipment and services CODE: A0426-F</td>
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<td></td>
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</tr>
</tbody>
</table>

- *2012: $14,051,114*  
  *Change 2012-13: -45.06%*
## Provider's Services in Detail

Services for which Medicare was reimbursed by Medicare:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number performed</th>
<th>Number of Medicare patients</th>
<th>Average Medicare reimbursement per procedure</th>
<th>Total Medicare payments for procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALSI-emergency</td>
<td>475</td>
<td>301</td>
<td>$381.68</td>
<td>$181,298.00</td>
</tr>
<tr>
<td>Equipment and services CODE: A0427-F</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground mileage</td>
<td>14,394</td>
<td>390</td>
<td>$6.54</td>
<td>$94,136.76</td>
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<tr>
<td>Equipment and services CODE: A0425-F</td>
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<td></td>
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<tr>
<td>Als 1</td>
<td>162</td>
<td>148</td>
<td>$243.78</td>
<td>$39,492.36</td>
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<tr>
<td>Equipment and services CODE: A0426-F</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Showing 1 to 3 of 3 entries

Previous 1 Next
PHILADELPHIA

• Since 2011, an ongoing Medicare Task Force in the Philadelphia metropolitan area has investigated 8 ambulance companies in connection with billing improprieties related to the transportation of dialysis patients
  – 60 arrests
  – 35 convictions and counting
    • Total of more than 300 years in prison terms
PHILADELPHIA

• Owner of Brotherly Love Ambulance was sentenced to more than 5 years in prison and ordered to pay more than $2 million in restitution for his role in a massive fraud scheme
  – Company would transport patients to and from dialysis using personal vehicles, and then falsify documentation to make it appear they received ambulance transportation
  – Former employees and patients have also plead guilty to their roles
PHILADELPHIA

• Husband of the owner of Superior EMS Ambulance was sentenced to more than 13 years in prison and ordered to pay $1.9 million in restitution for his role in a Medicare fraud scheme involving dialysis patients

  – He would transport patients in private vehicle or an ambulance and then falsify trip reports to make it appear the transports were medically necessary
HARRISBURG, PA

- Owner of Advantage Medical Transport was sentenced to 2 years in prison and nearly $500K in fines and restitution
- Previously plead guilty to charges of Medicare fraud in connection with medically unnecessary dialysis transports between 2009 – 2011
NORTH CAROLINA

• President of Crystal Coast Medical Transport (Morehead City, NC) plead guilty to perjury in connection with the submission of false health care claims
• Company employees were videotaped transporting patients in ambulances that were ambulatory and/or able to use wheelchairs
• PCS forms were altered to make it appear these patients required an ambulance
Owner of ProMed Medical Transportation was sentenced to 9 years in prison for masterminding a $1.5 million fraud scheme involving ambulance transports to and from dialysis.

- Case involved the submission of claims based on altered/falsified documentation to make it appear transports were medically necessary.
GUAM

- The owners and employees of Guam Medical Transport were indicted for operating an $11 million fraud scheme involving the transportation of dialysis patients
  - The company’s general manager was alleged to have coached patients to hide their ambulatory status to make it appear they required medical transportation
  - The company also paid patient’s personal expenses – including their Medicare Part B premiums – to ensure their eligibility for Medicare reimbursement
Report on Questionable Billing Practices

• September 29, 2015
• “Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports”
**Methodology**

- OIG analyzed claims data for 7.3 million ground ambulance transports during the first half of CY 2012
  - $2.9 billion in total Medicare payments
  - 2.9 million Medicare beneficiaries
  - 15,614 unique ambulance suppliers
**KEY FINDINGS**

- Medicare paid $24.2 million for ambulance transports that did not meet certain program requirements to justify payment
  - $17 million for transports to or from non-covered destinations
- Medicare paid $30.2 million for transports where the beneficiary did not receive Medicare services at either the origin or destination (or any other Medicare provider)
**Key Findings**

- 21% of ambulance suppliers tested “positive” for at least one of the 7 “questionable billing” practices the OIG examined
  - ~ 4% tested positive for 2 or more questionable billing practices
  - ~ 1% tested “positive” for 3 or 4 questionable billing practices
### Table 4: Questionable Billing Among Ambulance Suppliers, First Half of 2012

<table>
<thead>
<tr>
<th>Measure of Questionable Billing</th>
<th>Median Among All Suppliers</th>
<th>Suppliers That Had Questionable Billing</th>
<th>Number of Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Medicare Service at the Origin or Destination</td>
<td>0 transports</td>
<td>3%</td>
<td>2,038</td>
</tr>
<tr>
<td>Excessive Mileage for Urban Transports</td>
<td>10 miles</td>
<td>34 miles</td>
<td>642</td>
</tr>
<tr>
<td>High Number of Transports per Beneficiary¹</td>
<td>4 transports</td>
<td>21 transports</td>
<td>533</td>
</tr>
<tr>
<td>Compromised Beneficiary Number</td>
<td>1%</td>
<td>7%</td>
<td>358</td>
</tr>
<tr>
<td>Inappropriate or Unlikely Transport Level</td>
<td>&lt;1%</td>
<td>3%</td>
<td>268</td>
</tr>
<tr>
<td>Beneficiary Sharing¹,²</td>
<td>1.2 suppliers</td>
<td>2.3 suppliers</td>
<td>168</td>
</tr>
<tr>
<td>Transports to or From PHPs</td>
<td>0 transports</td>
<td>&lt;&lt;1%³</td>
<td>127</td>
</tr>
</tbody>
</table>

**Note:** We identified suppliers that had questionable billing and calculated median levels for each measure among all suppliers to which the measures applied. For example, the measure “excessive mileage for urban transports” applies to suppliers with urban transports. Appendix B provides a detailed description of how each measure was calculated.

¹ Among suppliers that provide dialysis-related transports.
² As represented by the number of suppliers per beneficiary.
³ <<1% means that the number would round to 0, but is above 0.

INVESTIGATION RESULTS
“INAPPROPRIATE OR UNLIKELY” TRANSPORT LEVEL/DESTINATION COMBINATIONS

• $4.3 million paid for SCT transports between origin/destinations other than hospitals, SNFs or intercept sites
  – $2.6 million for SCT between SNF and a free-standing dialysis facility (“J”)
  – $0.9 million for SCT between residences and free-standing dialysis facilities
“INAPPROPRIATE OR UNLIKELY” TRANSPORT LEVEL/DESTINATION COMBINATIONS

• $2.7 million for emergency transports to non-hospital destinations
  – $1.6 million for emergency transports to SNFs
  – $0.7 million for emergency transports to a patient’s residence
NO MEDICARE SERVICES RECEIVED

• The OIG flagged suppliers with a “high percentage” of transports for which the beneficiary did not receive Medicare services at either the origin or the destination on the date of service, plus or minus one day
  – To account for the possibility that the supplier incorrectly identified the origin/destination, the OIG indicated that it also looked to see if the beneficiary received services at any other Medicare provider within that time frame
EXCESSIVE URBAN MILEAGE

- The OIG flagged suppliers that had a high average mileage for their urban transports
  - The typical ambulance supplier had an average urban transport distance of 10 miles
  - The OIG flagged 642 suppliers (4%) with an average urban transport distance of 34 miles or more
  - 48 suppliers had an average urban transport mileage in excess of 100 miles
EXCESSIVE URBAN MILEAGE

• 642 ambulance suppliers (4%) had average urban transport mileage in excess of 34 miles

• 48 suppliers had an average urban transport mileage in excess of 100 miles
**HIGH NUMBER OF TRANSPORTS PER BENEFICIARY**

- The OIG flagged suppliers that had a high number of transports per beneficiary
  - i.e., large dialysis populations relative to their overall transport population

- The typical supplier provided an average of 4 transports per beneficiary
  - The OIG flagged 533 suppliers that had an average of 21 transports per beneficiary
The OIG flagged suppliers that had a high percentage of their transports associated with Beneficiary ID numbers that the OIG believes were “compromised”

The typical supplier that billed for any transports involving the use of compromised ID numbers had it occur less than 1% of the time

- The OIG identified 358 suppliers that used a compromised ID number on at least 7% of their transports
- The OIG identified 31 suppliers that used a compromised ID number on more than 95% of their transports
**Beneficiary Sharing**

- The OIG flagged suppliers that were associated with beneficiaries who, on average, received dialysis transports from an unusually high number of ambulance suppliers.
- The typical dialysis patient received their ambulance services from a single ambulance supplier.
  - The OIG identified 168 suppliers that were associated with beneficiaries that received dialysis services from at least 2 ambulance suppliers.
“When multiple suppliers bill for dialysis-related transports for the same beneficiary, the suppliers may have fraudulently shared beneficiaries or beneficiaries’ identification number with other suppliers. Alternatively, beneficiaries transported by these suppliers may have “shopped” among suppliers to receive kickbacks.”
PARTIAL HOSPITALIZATION PROGRAMS

• The OIG flagged suppliers that were involved in transporting patients to and from partial hospitalization programs (PHPs)
• The typical ambulance supplier had no transports to/from PHPs
  – The OIG identified 127 suppliers that had transported patients to/from PHPs
  – 59 suppliers had at least 75% of their transports involve PHPs
“Suppliers with questionable billing for this measure may have billed for transports to or from PHPs for beneficiaries who do not qualify to receive the transports. Beneficiaries who meet Medicare coverage requirements for PHPs generally do not meet the requirements for transports. For example, a beneficiary who is being transported because he is a danger to himself would not qualify to receive PHP services.”
INAPPROPRIATE TRANSPORT COMBINATIONS

• The OIG flagged suppliers that had a high percentage of transports involving unlikely or inappropriate transport level/destination combinations

• The typical ambulance supplier had less than 1% of its transports involve these combinations
  – The OIG identified 268 suppliers that had at least 3% of their transports involve these combinations
  – The OIG identified 19 suppliers that had at least 25% of their transports involve these combinations
ADDITIONAL FINDINGS
“NON-EMERGENCY TRANSPORTS”

• Ambulance suppliers flagged as having one or more questionable billing practices tended to provide primarily BLS non-emergency transports
  – 65% of their total transports

• BLS non-emergency transports account for only 36% of transports billed by all other suppliers
Table 5: Questionable Ambulance Transports and All Ambulance Transports That Were Provided to Beneficiaries Who Resided in Four Metropolitan Areas, First Half of 2012

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage of National Total</th>
<th>Medicare Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Questionable Transports</td>
<td>All Transports</td>
</tr>
<tr>
<td>Philadelphia, Pennsylvania</td>
<td>15.2%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Los Angeles, California</td>
<td>15.2%</td>
<td>4.7%</td>
</tr>
<tr>
<td>New York, New York</td>
<td>13.4%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Houston, Texas</td>
<td>8.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total in All Four Areas</td>
<td>52.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td>All Other Areas</td>
<td>48.0%</td>
<td>82.0%</td>
</tr>
</tbody>
</table>

Notes: Columns may not sum to totals because of rounding. Of the 951 other areas, 133 did not have any questionable transports.
Houston

- 2% of all ground ambulance transports
- 39% of transports involving compromised ID numbers
- 97% of questionable transports to or from Partial Hospitalization Programs
Final Anti-Discrimination Rules

On May 13, 2016, HHS issued final regulations designed to implement explicit protections from discrimination on the basis of gender identity

– Aimed primarily – but not exclusively – at health plans
“Taglines”

• Covered entities must post notices of nondiscrimination and “taglines” that alert individuals with limited English proficiency about the availability of language assistance services
  – Must be posted in at least the top 15 non-English languages spoken in the state
HIPAA Audit Program – Phase 2

• HHS Office of Civil Rights has announced an ambitious audit program for 2016
• Phase 1 completed December 2012
• Phase 2 will focus on policies and procedures implemented to ensure compliance with Privacy, Security and Notice of Breach Rules
  – Covered entities AND business associates
STAGES OF PHASE 2

• Stage 1 – Contact verification
  – Emails sent to covered entities and business associates to confirm mailing addresses and other contact information

• Stage 2 – Questionnaires
  – Surveys designed to get a sense of an entity’s size, scope, and nature of operations

• Stage 3 – Audit Subject Pools

• Stage 4 – Audit notification letters and document requests

• Stage 5 – Findings and entity input
HIPAA VIOLATION

• Lahey Hospital & Medical Center (Burlington, VT) paid $850K in fines related to the breach of patient protected health information
  – Stolen laptop used to operate a CT scanner contained information on 599 patients
  – Stolen from an unlocked treatment room in 2011
GAO REPORT ON CMS AUDIT ACTIVITIES

• May 13, 2016
• Report on comparative effectiveness of
  – RACs v. MACs
  – Prepayment v. Postpayment Reviews
GAO REPORT ON CMS AUDIT ACTIVITIES

• Key Findings:
  – RACs limited themselves to postpayment reviews
    • Primarily Hospital Inpatient Claims
  – MACs focused almost exclusively on prepayment reviews
    • Physician and other Part B claims
Key Findings:

- RACs identified $4.5 billion in improper payments during FY 2013 and FY 2014
- Paid $312 million
  - $14 in improper payments per dollar paid
GAO REPORT ON CMS AUDIT ACTIVITIES

• Key Findings:
  – MACs failed to report reliable data on the costs and effectiveness of their program integrity activities
• Recommendations:
  – CMS should seek legislation to permit RACs to transition to prepayment reviews
    • CMS disagreed with the recommendation, noting that it had other programs in place to avoid “pay and chase”
  – CMS should clarify the reporting obligations of MACs with respect to program integrity reviews
OIG REPORT ON UTILIZATION

• Between 2002 – 2011:
  – 269% increase in dialysis transports
    • 85% increase in number of ESRD patients
OIG REPORT ON UTILIZATION

• Between 2002 – 2011:
  – 69% increase in Part B ambulance transports
  – 34% increase in number of beneficiaries requiring ambulance transport
  – 26% increase in number of ambulance suppliers
    • ~ 100% increase in number of BLS-NE suppliers
  – 829% increase in transports to partial hospitalization programs
Key Findings:

- Number of ambulance providers has grown steadily since 2007
- Ambulance volume increased by 10% from 2007 to 2011
  - Most of increase in volume was from increase in BLS-NE
  - Dialysis in particular
  - Increase centered in urban areas
Rapid increase in dialysis-related transports and inappropriate billing for non-emergency transports

Ambulance spending per dialysis beneficiary by state, 2009

Source: United States Renal Data Systems, 2009, Average ambulance spending by state per beneficiary hemodialysis year
Novitas replaced TrailBlazer as Part B MAC in October 2012
FUTURE OF DIALYSIS

• Future Congressional Action
  – Further reductions to Fee Schedule Payments
  – Cap on number of covered ambulance trips
    • Per patient per year
    • Similar to physical therapy caps
  – Possible expansion of dialysis payment bundle
  – “Safe harbors” to induce dialysis facilities to transport their own patients

• Increase in Enforcement Activity

• Prior Authorization!!!
Operation of Prior Authorization Program
Process for Obtaining Prior Authorizations

• Medicare contractors will continue to process claims for the first three round trips with a 30-day period for the beneficiary

• Starting with the fourth round-trip claims will be subjected to a pre-payment medical review
  – Unless a prior authorization request has been submitted and approved
Prior Authorization Request

- Requests can be submitted by mail, fax, or through the Electronic Submission of Medical Documentation (esMD)
Response Time Frame

• Medicare contractors will “make every effort” to postmark decisions on an initial submission within 10 business days – 20 business days for a resubmission
Tracking Numbers

• Each request for a prior authorization will be assigned a “tracking number”
  – Unique Transaction Number (UTN)

• For approved requests, the tracking number must be submitted on subsequent claims
Approved Requests

• If approved, the MAC will authorize up to 40 round trips (80 total trips) for a 60-day period
  – Approval is provider-specific
  – Any provider submitting claims without a prior approval on record will be subject to prepayment review

Therefore, if two ambulance providers are both transporting the patient for a repetitive service (e.g., one to dialysis and another to wound care), both will need to obtain a prior authorization!!
Expedited Reviews

• CMS indicated that there will be a process for requesting an expedited review when the timeframe for making the prior authorization decision would jeopardize the life or health of the beneficiary
  – Decisions within 2 business days

• CMS indicated that it expects requests for expedited reviews to be “extremely rare”
Representative Payees

• Towards the end of December 2014, ambulance providers in the affected states were receiving “non-affirmations” indicating that the patient was not eligible for participation in the PA program because they had a “representative payee” on file with the SSA
  – i.e., an individual who was responsible for receiving their SS payments

• CMS confirmed that these patients were not included in the demonstration project
  – Submit claims without a UTN

• **Effective January 1, 2016 (or thereabouts)**
  Representative Payees are no longer excluded
HORROR STORIES

April

SATAN SENDS A RAT
by LORING DOWST
Novitas initially rejected PCS forms that were signed and dated with a date prior to December 15, 2014 (i.e., the start date of the program).

Catch-22: to cover trips on or after December 15, 2014, you needed to submit the prior authorization request prior to that date. If the PCS needed to be signed prior to the date you submitted your request...how could it be signed on December 15, 2014?
• Novitas would not accept portions of the MDS form
  – Novitas’ stated concern was that omitted portions contained information that conflicted with the information provided

  Catch-22: Novitas would not read the entire form if submitted
Novitas initially would not accept a letter from the physician indicating why the patient required an ambulance

- Novitas wanted to see the actual physician progress notes

Surreal: not only would Novitas refuse to assign any value to the physician’s letter, it would reject the entire request because it included an unacceptable documentation
1. Ambulance benefit is a limited one!!!
2. There exists some differences of opinion between the provider community and the MACs as to what constitutes a “covered” patient
3. Being “right” is less important than being in sync with your MAC!!!

On 12/1/2014, Ambulance Prior Authorization commenced for transports occurring on or after 12/15/2014 in NJ, PA, and SC.
Pre-Implementation
PRE-IMPLEMENTATION

• Seek clarity on your state and local regulatory environment
  – Does your state permit stretcher vans?
  – If so, are there any restrictions on their use?
  – Is your MAC aware of any such restrictions?
(a-1) A person may not transport a patient by stretcher in a vehicle unless the person holds a license as an emergency medical services provider issued by the department in accordance with this chapter. For purposes of this subsection, "person" means an individual, corporation, organization, government, governmental subdivision or agency, business, trust, partnership, association, or any other legal entity.
Initial Submission Checklist

• Create a list of all documents you will need for a new patient
  – Prior Request Cover Sheet
  – Valid PCS form
  – Supporting documentation

• SNF Minimum Data Set
Prior Authorization Form

Fields with a red asterisk (*) are required.

Request Type (Check One) *
- Initial
- Resubmission
- Please expedite this request

If you selected “Expedited” above, please provide a reason *

Number of Transports Requested (Round Trip = 2 Transports) *

Ambulance Supplier / Provider Information

Provider Name *

National Provider Identifier (NPI) *

Provider Number (PTIN) *

Provider Address *

Provider City *

Provider State *

Provider Zip *

State Where Ambulance is Garaged *

Beneficiary Information

Beneficiary First Name *

Beneficiary Last Name *

Health Insurance Claim (HIC) Number *

Beneficiary Date of Birth (mm/dd/yyyy) *

Beneficiary Gender *
- Male
- Female

A decision letter will be mailed to the address provided. If you would also like a faxed copy, please give your fax number below.

Start of 60 Day Period (mm/dd/yyyy) *

Claim Information

Certifying Physician Name *

Certifying Physician NPI *

Certifying Physician PTIN *

Certifying Physician Address *

Certifying Physician City, State, Zip *

Modifier 1 *

Modifier 2 *

Requestor Information

Requestor Name *

Requestor Phone Number & Extension *

Signature *

Date *

Please Do Not Copy

Prior Authorization Request Repetitive Non Emergent Ambulance
Medicare Part B Fax/Mail Cover Sheet

Complete all fields, attach supporting medical documentation (i.e. Physician Certification Statement, medical records that support medical necessity, etc.) and fax to 877-439-5479 or mail to the applicable address/number provided at the bottom of the page. Complete ONE (1) Medicare Fax/Mail Cover Sheet for each prior authorization request for which documentation is being submitted.

Beneficiary Last Name: _____________________________
Beneficiary First Name: _____________________________

HCN: _____________________________
Gender:  ☐ Male  ☐ Female

DOB: _____________________________

Rendering Provider’s NPI: _____________________________

Rendering Provider’s Name and Address:

Contact Name: _____________________________
Contact Phone Number: _____________________________

Contact Fax Number: _____________________________

Procedure Code(s):

Number of Trips (Not to exceed 30 in 60 days):

State Where Services Were Provided: (select one)

Request Completed by: (please print and sign) _____________________________ Date: _____________________________

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1. ADL Self-Performance
Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time.

Coding:
- Activity Occurred 3 or More Times
  0. Independent - no help or staff oversight at any time
  1. Supervision - oversight, encouragement or cueing
  2. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
  3. Extensive assistance - resident involved in activity, staff provide weight-bearing support
  4. Total dependence - full staff performance every time during entire 7-day period

- Activity Occurred 2 or Fewer Times
  7. Activity occurred only once or twice - activity did occur but only once or twice
  8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

B. Transfer - how resident moves between surfaces Including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)

C. Walk in room - how resident walks between locations in his/her room

D. Walk in corridor - how resident walks in corridor on unit

E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once In chair

F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair

2. ADL Support Provided
Code for most support provided over all shifts; code regardless of resident's self-performance classification

Coding:
- No setup or physical help from staff
- Setup help only
- One person physical assist
- Two+ persons physical assist

- ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

<table>
<thead>
<tr>
<th>Self-Performance</th>
<th>Support</th>
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</table>

Enter Codes in Boxes
### G0300. Balance During Transitions and Walking

After observing the resident, code the following walking and transition items for most dependent

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
<th>8</th>
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<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Moving from seated to standing position</td>
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<td>B. Walking (with assistive device if used)</td>
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<td>C. Turning around and facing the opposite direction while walking</td>
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<td>D. Moving on and off toilet</td>
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<td>E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)</td>
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</table>

**Coding:**

0. Steady at all times
1. Not steady, but able to stabilize without staff assistance
2. Not steady, only able to stabilize with staff assistance
8. Activity did not occur
### G0400. Functional Limitation in Range of Motion

**Code for limitation that interfered with daily functions or placed resident at risk of injury**

<table>
<thead>
<tr>
<th>Coding</th>
<th>Enter Codes in Boxes</th>
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<tbody>
<tr>
<td>0. No impairment</td>
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<tr>
<td>1. Impairment on one side</td>
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<tr>
<td>2. Impairment on both sides</td>
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</tbody>
</table>

- A. Upper extremity (shoulder, elbow, wrist, hand)
- B. Lower extremity (hip, knee, ankle, foot)

### G0600. Mobility Devices

**Check all that were normally used**

- A. Cane/crutch
- B. Walker
- C. Wheelchair (manual or electric)
- D. Limb prosthesis
- Z. None of the above were used
Review of Current Patients

• Critical that you conduct a review of current repetitive patient population
  – Confirm that they meet medical necessity
  – Identify areas of weakness with your documentation
RISK PROFILES

• One option is to categorize your repetitive patients based on the likelihood that they will be approved for prior authorization
  – High – almost certain to be approved
  – Medium
  – Low – likely to be rejected
Post-Implementation
Next Steps?
Options

1. Resubmit for approval
   – Likely will require additional documentation

2. Submit individual claims
   – Will be denied
   – Will require appeals

3. Ask yourself, is it possible the MAC is correct?
3 Months In…

• You want to try and get a sense of how strict (or how lenient) your MAC is being with granting prior approvals
  – This should guide your long-term strategy for handling repetitive patients
• MAC is consistently rejecting even those patients you categorized as “high” likelihood
• MAC is consistently approving even those patients you categorized as “low” likelihood