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# 2022 Texas EMS Alliance Association

## Ambulance Prior Authorization

August 16, 2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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# Today's Presentation

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- Agenda:
  - Prior Authorization Changes
  - Prior Authorization Process
  - Ambulance Policy and Requirements for Coverage Reminders
  - Prior Authorization Documentation
  - Common Reasons for Non-Affirmed Decisions
  - RSNAT PA FAQs
  - References and Prior Authorization Contact Information
- Objectives
  - Detail the changes due to implementing the prior authorization
  - Discuss the process for prior authorization
  - Cover the ambulance policy and requirements for coverage
  - Discuss the common reasons for non-affirmed decisions
  - Cover FAQs for RSNAT Prior Authorization
  - Provide references, contact information and update information

# Acronym List

| Acronym | Definition |
|---|---|
| ADR | Additional Documentation Request |
| BLS | Basic Life Support |
| CMS | Centers for Medicare & Medicaid Services |
| CPT | Current Procedural Terminology |
| FAQs | Frequently Asked Questions |
| HCPCS | Healthcare Common Procedure Coding System |
| LCD | Local Coverage Determination |
| LCDA | Local Coverage Determination Article |
| MAC | Medicare Administrative Contractor |
| PA | Prior Authorization |
| PCS | Physician Certification Statement |
| PTAN | Provider Transaction Access Number |

# Acronym List Two

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| Acronym | Definition |
|---|---|
| RSNAT | Repetitive, Scheduled Non-Emergent Ambulance Transport |
| UTN | Unique Tracking Number |

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# Prior Authorization Changes

# Suppliers Utilizing the Prior Authorization Process: Affirmed Decision

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- Changes due to the prior authorization process:
  - Ambulance suppliers utilizing the prior authorization process:
    - ✓ Submit medical records supporting the medical necessity using the prior authorization process
    - ✓ Both the beneficiary and supplier will be notified of the decision
    - ✓ Affirmed decision:
      - ➢ The medical records supported the medical necessity of the transports
      - ➢ The notification will include an affirmed UTN and the number of trips approved
      - ➢ Claims can be submitted with the approved UTN and will process for payment
      - ➢ Appeal rights still apply
      - ➢ Claims for non-repetitive transports for beneficiaries with a UTN on file for the supplier could be subject to complex medical prepayment review
      - ➢ Novitas could conduct complex medical prepayment reviews on ambulance claims for any beneficiary determined to be a recipient of repetitive services

# Suppliers Utilizing the Prior Authorization Process: Non-Affirmed Decision

- Non-affirmed decision:
  - The documentation did not support the medical necessity of the transports
  - The decision letter will include an unaffirmed UTN and a detailed explanation of why the prior authorization was not approved
  - Suppliers have two options:
    - ✓ Option One:
      - ➢ Suppliers can provide the service and submit a claim:
        - » If billed correctly with the non-affirmed UTN, the claim will process normally and will be denied
      - ➢ All appeal rights are available for the claim denial:
        - » Appeals do require documentation to support the medical necessary of the transport
    - ✓ Option Two:
      - ➢ Resolve the deficiencies or errors described in the decision letter, complete a new cover sheet, gather all medical records and a valid PCS, and resubmit the prior authorization request:
        - » No limit to number of resubmissions
        - » These requests are not considered appeals
        - » Re-submission must include a new coversheet, valid PCS, the medical records must be valid for the requested timeframe and the UTN will need to be completed on the form
        - » Documentation must support each record

# Suppliers not Utilizing the Prior Authorization Process

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- The Authorization Process is not mandatory; however, Novitas Solutions and CMS strongly encourage ambulance suppliers to use the Medicare prior authorization process
- Without a prior authorization decision, the supplier and the beneficiary will not know if the service meets the criteria for payment prior to the transport being rendered
- Ambulance supplier not utilizing the prior authorization process:
  - Medicare will allow six-round trips, without reviewing the medical records
  - Before the seventh-round trip will be processed (paid or denied), an ADR will be sent requesting medical documentation
  - The supplier will need to submit the documentation within 30 days
  - Once the documentation is received, we have 30 days to review the documentation
  - This can delay payment due to the ADR timeframe and our medical review timeframe to review received documentation
  - Payment may be denied if the documentation does not support the medical need for transport
  - Supplier will then need to appeal the denied claim with documentation to support the medical necessity
  - Novitas could conduct complex medical prepayment reviews on ambulance claims for any beneficiary determined to be a recipient of repetitive services

# Who and What

- Suppliers who can request a Prior Authorization:
  - Ambulance suppliers not institutionally based, that provide Part B Medicare-covered ambulance services and are enrolled as independent ambulance suppliers
- Excluded Suppliers:
  - Ambulance suppliers under review by the Unified Program Integrity Contractor (UPIC) are not eligible to submit prior authorization requests
  - Indian Health suppliers are excluded from the RSNAT PA
- Type of Transports:
  - Repetitive scheduled non-emergent ambulance transport claims not included in a covered Part A stay
  - Billed on a CMS 1500 form and/or Health Insurance Portability and Accountability Act (HIPAA) compliant American National Standards Institute (ANSI) X12 N837P electronic transaction

# What is a Repetitive Ambulance Service?

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- Definition of Repetitive Ambulance Service:
  - 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 or cancer treatment

# HCPCS Codes

- The following codes are subject to prior authorization:
  - A0426 – Ambulance service, advanced life support (ALS), non-emergency transport, Level 1
  - A0428 – Ambulance service, basic life support (BLS), non-emergency transport
  - Note: The mileage code, A0425, will be handled as an associated procedure for prior authorization processing and should always be billed in conjunction with the transport code:
    - ✓ Prior authorization is not needed for A0425
- No prior authorization decisions will be made on any other code
- If Novitas receives a prior authorization request for a code other than A0426 or A0428, the request will not be reviewed, and a decision letter will not be sent

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# Prior Authorization Process

# Standardized Coversheet for RSNAT

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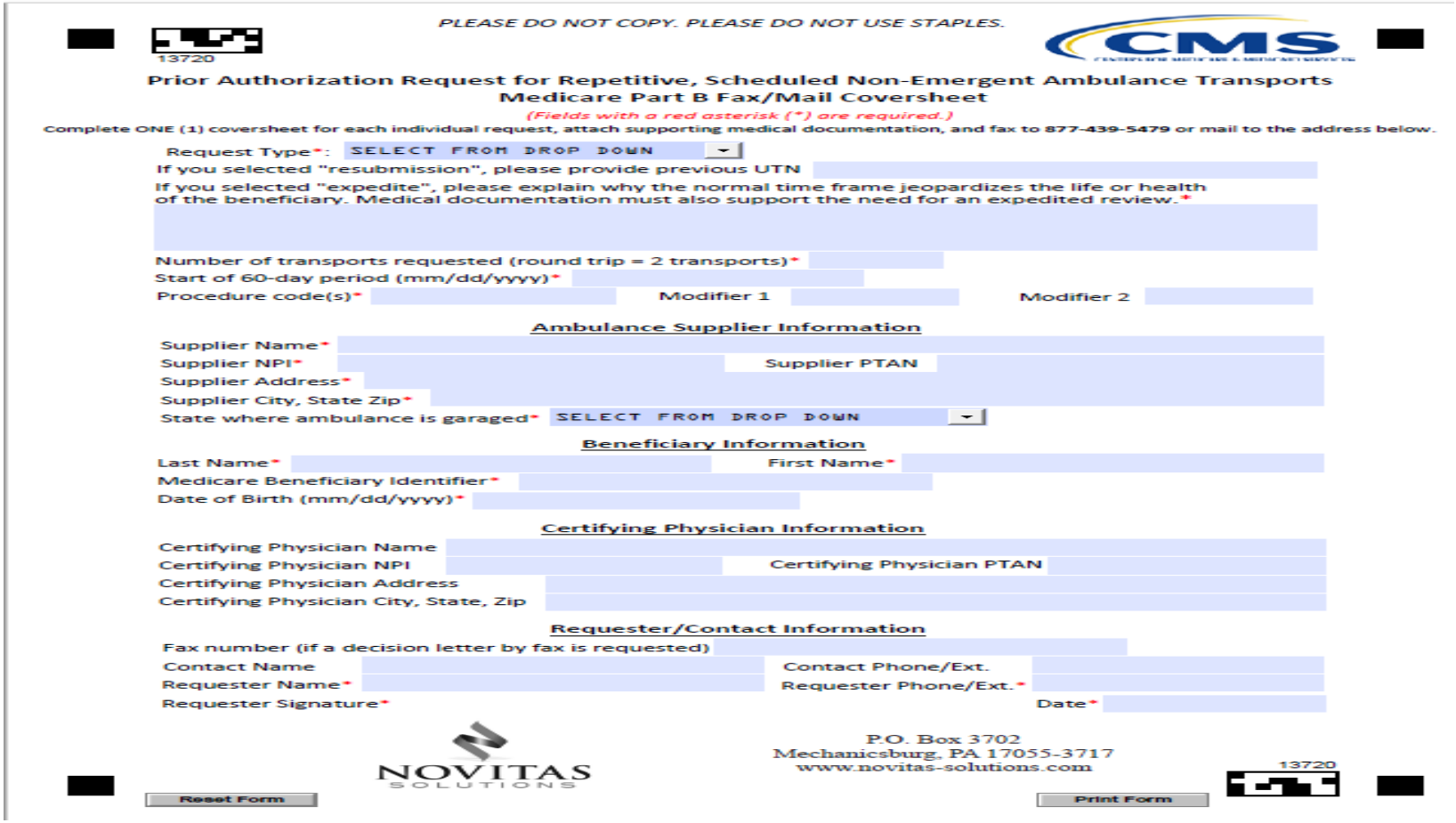
- CMS standardized the Prior Authorization Request Cover Sheet used in the RSNAT Prior Authorization Model for all MAC jurisdictions
- This sheet is used for all RSNAT requests which includes initial, resubmission and expedited requests
- Prior Authorization Request Repetitive Non-Emergent Ambulance Medicare Part B Fax/Mail Cover Sheet (JH) (JL):
  - Failure to populate the required fields could result in delays in processing your request
  - Using any other form or any other fax number, the Prior Authorization will not be considered
- Instructions for completing the Prior Authorization Request Cover Sheets for Non-Emergent Ambulance Services (JH) (JL)

# Prior Authorization Request Fax/Mail Coversheet



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**Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports**
**Medicare Part B Fax/Mail Coversheet**

*(Fields with a red asterisk (*) are required.)*

Complete ONE (1) coversheet for each individual request, attach supporting medical documentation, and fax to 877-439-5479 or mail to the address below.

Request Type*: SELECT FROM DROP DOWN

If you selected "resubmission", please provide previous UTN

If you selected "expedite", please explain why the normal time frame jeopardizes the life or health of the beneficiary. Medical documentation must also support the need for an expedited review.*

Number of transports requested (round trip = 2 transports)*

Start of 60-day period (mm/dd/yyyy)*

Procedure code(s)* Modifier 1 Modifier 2

**Ambulance Supplier Information**

Supplier Name*

Supplier NPI* Supplier PTAN

Supplier Address*

Supplier City, State Zip*

State where ambulance is garaged* SELECT FROM DROP DOWN

**Beneficiary Information**

Last Name* First Name*

Medicare Beneficiary Identifier*

Date of Birth (mm/dd/yyyy)*

**Certifying Physician Information**

Certifying Physician Name

Certifying Physician NPI Certifying Physician PTAN

Certifying Physician Address

Certifying Physician City, State, Zip

**Requester/Contact Information**

Fax number (if a decision letter by fax is requested)

Contact Name Contact Phone/Ext.

Requester Name* Requester Phone/Ext.*

Requester Signature* Date*

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P.O. Box 3702
Mechanicsburg, PA 17055-3717
www.novitas-solutions.com

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Reset Form Print Form

# Required Medical Records

- The PA coversheet should be submitted with the prior authorization request and documentation supporting the medical necessity of the transport
- The CMS Repetitive Scheduled Non-Emergent Ambulance Transport Model Operational Guide lists the required medical records
- Medical records should provide sufficient information, in the form of objective findings and clinical assessment data, to support the cover sheet data and the PCS:
  - A signed and dated PCS does not, by itself, demonstrate that the repetitive scheduled transports are medically necessary
- Note: A signed and dated attestation letter (prepared statement) alone cannot support medical necessity
- The clinical assessment provided by the ambulance supplier alone cannot support the medical necessity of transports, there must be additional documentation from the provider or facility to justify the transport

# Prior Authorization Request Submission

- The ambulance supplier or the beneficiary may submit the request
- The request can be submitted by one of these options:
  - Novitasphere Web Portal (JH) (JL)
  - Electronic Submission of Medical Documentation (esMD) system:
    - ✓ Indicate document type "81"
  - Faxed to 1-877-439-5479
  - Mailed to:
    - ✓ 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

# Review Timeframes

- Initial Requests:
  - The first prior authorization request for any 60-day period
  - Novitas makes every effort to review the request 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
  - Novitas makes every effort to review the request and postmark decision letters within 10 business days
- Expedited Circumstances:
  - The request submitted when the standard timeframe could jeopardize the life or health of the beneficiary:
    - ✓ Should be extremely rare for non-emergency transports
  - Novitas will make reasonable efforts to communicate a decision within two business days

# Detailed Decision Letter

- Decision letters are sent directly to the Ambulance supplier and the beneficiary
- Decision letters include the prior authorization Unique Tracking Number (UTN) that must be submitted on the claim
- Decision letters that do not affirm the prior authorization request:
  - Provide a detailed written explanation outlining which specific policy requirement(s) was/were not met

# Unique Tracking Number (UTN)

- UTN will be provided on the decision letter
- Affirmed or Non-Affirmed the UTN must be submitted on the claim
- EDI Claims:
  - Report in 2300, the Claim Information loop, or 2400, the Service Line loop, in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3)
- CMS 1500 Claim Form, report in the first 14 positions in Item 23:
  - All other data submitted in Item 23 must begin in position 15

# Claim Reject and Prepay Review for Certain Transports

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- If the provider has a UTN for a beneficiary and the provider submits a claim for a repetitive transport for that beneficiary without the UTN:
  - Then the claim will reject, and the provider will then have to resubmit the claim with the UTN
- Claims for non-repetitive transports for beneficiaries with a UTN on file for the provider could be subject to complex medical prepayment review
- Novitas could conduct complex medical prepayment reviews on ambulance claims for any beneficiary determined to be a recipient of repetitive services:
  - If you are subject to complex medical prepayment review, the most efficient method is to send in one package at a time

# Common Submission Errors

- The following submissions errors have been identified:
  - Ambulance Prior Authorization requests on the incorrect form:
    - ✓ In order to submit a prior authorization for ambulance repetitive services, the request must be submitted on the Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports Medicare Part B Fax/Mail Coversheet If you have submitted a request on the incorrect form, please resubmit the request on the proper form
- Only one round trip is being requested:
  - A supplier can receive provisional prior authorization for as many as 40 round trips (80 one-way transports) in a 60-day period
  - To save suppliers time on submitting the requests, we ask that you submit more than one round trip per request

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# Ambulance Policy and Requirements for Coverage Reminders

# Unchanged

- Requirements that did not change when the prior authorization process began:
  - ✓ The Ambulance Medicare coverage policies
  - ✓ Documentation requirements
  - ✓ PCS requirements
  - ✓ "Painting the picture" of the patient condition
  - ✓ Signature guidelines and requirements
- The Novitas Ambulance LCD and Article, contains the coverage and documentation requirements

# CMS National Ambulance Policy

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- Medicare covers both emergency ambulance transportation and non-emergency ambulance transportation based on medical necessity
- The Medicare payment benefit for ambulance services is very restricted, which means the ambulance services are covered only if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health:
  - A patient must have a health problem to the degree that transport, such as a wheelchair van or private car, could put their health and safety at risk
  - Not covered when the patient's condition permits transport in any type of vehicle other than an ambulance
- This usually means that the beneficiary is bed-confined and/or meets the criteria for medical necessity as defined and detailed in the Novitas Ambulance LCD and Article, which repeats CMS National Policy
- The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 C.F.R. §410.40(d)
- Payment depend on beneficiary's condition at actual time of transport regardless of diagnosis
- Patient must require the transportation and level of service provided
- Transportation is to the closest appropriate facility

# CMS Definition of Bed-Confinement

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- Definition:
  - Unable to get up from bed without assistance
  - Unable to ambulate
  - Unable to sit in a chair or wheelchair
- Note:
  - All three must be meet and documentation must support the bed-confinement definition:
    - ✓ Documentation must paint the picture of why the patient cannot go safely by other means of transportation
    - ✓ The term “bed confined” is not synonymous with “bed rest” or “non-ambulatory”
  - Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits
  - It is simply one element of the beneficiary’s condition that may be taken into account in Novitas’ determination of whether means of transport other than an ambulance were contraindicated

# Ambulance Coverage Destinations and Facilities

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- Coverage Destinations:
  - Only to the following destinations:
    - ✓ Hospital
    - ✓ Critical Access Hospital (CAH)
    - ✓ Skilled Nursing Facility (SNF)
    - ✓ Beneficiary's home.
    - ✓ Dialysis facility for End Stage Renal Disease (ESRD) patient who requires dialysis
- Covered to the nearest appropriate facility
- Mileage to the nearest appropriate facility covered
- Appropriate Facilities:
  - The term appropriate facilities means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved
  - In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition

# Coverage and Documentation

- The Novitas Ambulance LCD L35162 states the records submitted should include the following:
  - Documentation that supports medical necessity of ambulance transport
  - Documentation supporting the number of loaded miles billed:
    - ✓ Origin (point of pickup) and destination (point of drop off)
  - Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s))
  - The medical record documentation must support the medical necessity of the services as stated in this policy
  - It is the responsibility of the ambulance supplier to maintain (and furnish to Medicare upon request) complete and accurate documentation of the beneficiary's condition to demonstrate the ambulance service being furnished meets the medical necessity criteria
  - Documentation must be legible or identifiable and signed (submitted with a signature log)

# Physician Certification Statement (PCS) Requirements

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- The PCS is required for scheduled and non-scheduled non-emergency transports for patients who are under the direct care of a physician
- The PCS should contain current information about the beneficiary's condition, to include diagnoses and a description of the beneficiary's condition(s) that necessitate the type and level of transports requested
- Ambulance suppliers are responsible for maintaining a valid PCS at all times
- Novitas reserves the right to request the PCS at any time
- Each individual time a patient is transported by ambulance, that transport must be reasonable and necessary regardless of whether a new prior authorization is required

# PCS Form

- The signed PCS does not, by itself, demonstrate that the transport was medically necessary and does not absolve the ambulance provider from meeting all other coverage and documentation criteria
- The PCS (JH) (JL) Must Be:
  - Be patient-specific
  - Contain pertinent medical information
  - For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days
  - Be signed and dated by the patient's attending physician on the date completed
  - The signature of the medical professional completing the PCS must be legible (or accompanied by a typed or printed name) and include credentials:
    - ✓ Credentials next to the signature will facilitate the prior authorization process
      - ➢ The prefix "Dr." is a title and not a credential
    - ✓ Stamped signatures or on file signatures are not acceptable

# Signatures

- Signatures, including credentials, from the person(s) responsible for the care of the beneficiary must be documented:
  - Medicare requires that services provided/ordered/certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies
  - The method used must be a handwritten or electronic signature
  - Stamped signatures are not acceptable. Information regarding signature requirements of the person(s) responsible for care may be found in IOM Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4:
    - ✓ Information regarding the signature requirements on the "Physician Certification Statement (PCS)" can be found in the above reference
  - Beneficiary signature requirements related to ambulance services, may be found in IOM Pub.100-02, Medicare Benefit Policy Manual, Chapter 10, Section 20.1.2, and CFRs referenced in this policy

# Signature Guidelines for Medical Review Purposes

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- Medicare requires that services provided/ordered be authenticated by the author:
  - Method used shall be a handwritten or an electronic signature
  - Stamped signatures are not acceptable
- These guidelines impact the ambulance trip/run sheets and the PCS
- Signature of the medical professional completing the PCS must be:
  - Legible (or accompanied by a type or printed name) and include credentials
  - Dated at the time they are completed
- All signature requirements are effective for Comprehensive Error Rate Testing (CERT)
- All signature requirements for Affiliated Contractors (AC), MACs and Unified Program Integrity Contractors (UPICs) are applicable for reviews conducted
- Reference:
  - Complying with Medicare Signature Requirements

# Additional Signature Guidelines for Medical Review Purposes

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- Trip/Run sheet signature requirements:
  - Must contain the date and legible signature of the observer and their credentials
  - Can print their name under the signature
  - Can submit a signature log

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# Prior Authorization Documentation

# Documentation Requirements

- To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services
- The primary reason prior authorization requests are non-affirmed is insufficient, incomplete or contradictory medical record entries
- Requests that do not have the required clinical assessment data and objective findings will receive a provisional non-affirmed decision
- Novitas Tools:
  - Ambulance Prior Authorization Documentation Requirements: (JH) (JL)
  - Repetitive Scheduled Non-emergent Ambulance Transport Prior Authorization Request Submission Checklist: (JH) (JL)
  - Ambulance Prior Authorization - Documentation Checklist for Medical Professionals: (JH) (JL)

# Ambulance Prior Authorization Documentation Requirements:

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- A complete request should have a completed cover sheet and the following items:
  - The PCS
  - Medical records with objective findings and clinical assessment data that provide information on the beneficiary's mobility and/or functional status and/or medical conditions listed on the PCS
  - The medical record must demonstrate that transportation by other means is contraindicated
  - Records with only vague statements, such as "patient is bed-confined" and “not safe to sit in a wheelchair”, are insufficient
- To be valid, the PCS cannot be dated more than 60 days in advance of the requested start date of service:
  - For example, a PCS signed 12/01/21 would not be valid for a request with a start date of 03/15/22

# Ambulance Prior Authorization Documentation Requirements: Types of Required Medical Records

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- Medical records should be current for the medical condition(s) that could necessitate the transports
- Medical records that describe the beneficiary's mobility and/or functional status or medical conditions(s) and support the PCS can include, but are not limited to:
  - Doctor's progress notes
  - Nursing notes
  - Physical or occupational therapy notes
  - History and Physical
  - Nursing Home MDS (minimum data set)
  - Hospital or facility admission and discharge summaries
- Medical records should be dated on or before the signature date of the PCS
- Every page of the medical record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s))
- The record must include the name of the physician or non-physician practitioner responsible for and providing the care of the patient, inclusive of their signature on the medical record
- Exact street address of the origin and destination of the transports (including ZIP Codes)
- Any other relevant medical record as deemed necessary by Novitas to process the prior authorization
- All records must contain valid signatures, including credentials and dated

# Documentation Checklist for Medical Professionals

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- As the ordering physician/practitioner, they are required to supply the ambulance supplier or beneficiary the physician certification statement (PCS) as well as any other documentation that supports medical necessity for the repetitive scheduled non-emergent ambulance transports
- CMS developed a letter to help suppliers obtain medical records from the physician/practitioner:
  - This letter explains the prior auth process and instructs them to comply with the suppliers and refers them to the ambulance policy
- Novitas developed this checklist that itemizes the medical record criteria for medical professionals (JH) (JL):
  - If suppliers are having a difficult time obtaining documentation, suppliers can provide this to providers:
    - ✓ Ensure the records you submit to the ambulance service supplier are acceptable and contain clinical assessment data that supports the medical necessity of the requested ambulance transports

# Medical Professionals: Medical record requirements

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- The record is specific to and regards a date of service that contains objective observations from a patient encounter:
  - ✓ For example, the record is an emergency room report, SNF record, dialysis facility record, hospital record, doctor's progress note, nurse's note, plan of care, MDS, interdisciplinary notes, physical or occupational therapy progress note
- The record is current
- The date of service for the record is on, or prior to, the signature date on the PCS
- The record is legible. Every page of the record is readable
- Every page of the record includes the appropriate patient identification information (complete name, date(s) of service(s))
- The record includes the physician or non-physician practitioner responsible for and providing the care of the patient
- The record is signed by the medical professional with a handwritten or electronic signature and should include credentials

# Medical Professionals: Supporting the PCS

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- The record supports the medical conditions itemized or checked on the PCS
- The record paints a comprehensive picture of the medical conditions itemized or listed on the PCS
- Statements such as the following, with absent supporting clinical assessment data with objective findings, are insufficient to justify Medicare payment for ambulance services:
  - Patient complained of shortness of breath
  - History of stroke
  - Contractures
  - Hypertension
  - Amputations
  - Chest pain
  - Paralysis
  - Generalized weakness
  - Ulcers
  - Is bed-confined or bedbound
  - A list of diagnoses
  - A list of treatments or medications to treat the diagnoses
- Medical records that indicate conditions such as the above should include objective findings and/or medical reasons on or for those conditions, such as bed-confinement

# Medical Professionals: Bed-confinement

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- To support bedbound status, all three elements of the definition must be adequately addressed in the medical records:
  - Unable to get up from bed without assistance
  - Unable to ambulate, and
  - Unable to sit in a chair (including a wheelchair)
- The records must contain:
  - Clinical assessment data, with objective findings, that reveals that the patient cannot get out of bed without assistance, and why
  - Clinical assessment data, with objective findings, that reveals that the patient is unable to ambulate, and why
  - Clinical assessment data, with objective findings, that reveals that the patient is unable to sit in a chair, and why
  - The clinical assessment data includes objective findings on each condition, including but not limited to:
    - ✓ Measurements
    - ✓ Degrees of magnitude or scale
    - ✓ Exact body location of condition
    - ✓ The origin or history of the condition
    - ✓ Timeframes and dates, such as upcoming treatment dates, expected duration of condition, or dates when treatment goals are anticipated to be attained

# Medical Professionals: Other medical condition(s) necessitating ambulance transport

- To support that the patient has a mobility status issue/condition that necessitates ambulance transport, the issue/condition and the reason why it mandates an ambulance transport must be described with clinical assessment data that includes objective findings
- The medical records must contain:
  - Clinical assessment data with objective findings that comprehensively describes the mobility status issue or condition
  - Clinical assessment data with objective findings that comprehensively explains why the condition/issue contraindicates transport by any means other than ambulance
- The clinical assessment data includes objective findings on each condition, including but not limited to:
  - Measurements
  - Degrees of magnitude or scale
  - Exact body location of condition
  - The origin or history of the condition
  - Timeframes and dates, such as upcoming treatment dates, expected duration of condition, or dates when treatment goals are anticipated to be attained

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# Common Reasons for Non-Affirmed Decisions

# PCS Errors

- Errors:
  - The submitted PCS was signed by a provider other than the attending physician
  - The PCS is dated more than 60 days before the date of the requested ambulance transport and is not a valid PCS
  - The PCS is missing the date that it was signed by the physician
  - A portion of the documentation on the PCS is not readable (legible)
  - The signature on the PCS is not readable (legible) and there is no typed or printed name on the PCS
  - The PCS does not support other documentation submitted

# Medical Record and Medical Necessity Errors

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- Medical Record Errors:
  - The medical record submitted on (Page #) is not readable (legible)
  - There is no readable (legible) physician and/or practitioner signature on (the record) submitted for review
  - The medical documentation received for review is not considered current medical records
  - There is no identifiable date of service on the medical records
  - The complete address for the beginning location (origin) and/or the ending location (destination) of the requested ambulance transport was not included in the documentation submitted for review
  - After review of the submitted documentation, it has been determined that the medical services needed by the patient at the ending location (destination) could be provided at the starting location (origin) of the requested non-emergent transport(s)
- Medical Necessity Unsupported by Records Errors:
  - The PCS states the patient needs non-emergent ambulance transport because he/she is bed-confined; however, after review of the submitted medical documentation, bed-confined status is not supported
  - The medical records received were insufficient to support non-emergency ambulance transport as medically reasonable or necessary
- Beneficiary May Not Qualify:
  - After reviewing the PCS and the medical records, it has been determined that the patient does not have a condition that supports the need for non-emergency ambulance transport to be medically reasonable and necessary
  - Documentation on the PCS does not state that there is a medical reason for non-emergent ambulance transport or that the beneficiary is bed-confined by Medicare standards

# Destinations and Additional Documentation Errors

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- Covered Destinations Error:
  - The ending location (destination) of the requested non-emergency transport is not covered under Medicare non-emergency ambulance transport guidelines
- Letters, Trip Sheets, and Statements Not Acceptable for the Prior Authorization Process:
  - Ambulance trip reports/run sheets are not acceptable as the only medical records for Prior Authorization
  - Attestation letters for medical necessity from healthcare providers are not acceptable as the only medical records
  - Letters from the patient and/or relatives are not medical records

# Missing or Conflicting Information Errors

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- Missing Information Errors:
  - The patient's identifying information on the PCS is incomplete or does not match our records
  - The patient's identifying information (i.e. name, date of birth, or Healthcare Identification Number) PCS does not match the information on (the medical records)
  - The medical record(s) is/are missing the patient's name/identifying information
- Conflicting Information Errors:
  - The medical record received contained conflicting information that does not support the patient as being bed-confined by Medicare standards thus not supporting non-emergency ambulance transport
  - The medical record received contained conflicting information that does not support the patient having a medical condition that would support the non-emergency ambulance transport as medically reasonable or necessary
  - The information on the PCS is conflicted by documentation contained in the medical records submitted for review

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# RSNAT PA FAQs

# Question #1

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- Question:
  - What is the latest date we can submit a prior authorization request?
- Answer:
  - Prior authorization requests are accepted when they are submitted with all the required information. To avoid claim payment delays, suppliers should submit prior authorization requests 10-15 days before the start of scheduled repetitive services. As a reminder, we have 10 days to review and provide a response once submitted.

# Question#2

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- Question:
  - Should the ambulance supplier get two prior authorizations if a beneficiary needs dialysis and chemotherapy?
- Answer:
  - No, the provisional affirmation decision and UTN will prior authorize up to 40 round trips in a 60-day period. Regardless of the treatment sought at the destination, as long as the transports are medically necessary, as supported by the medical records, and are repetitive and scheduled, they are provisionally prior authorized under the UTN.

# Question#3

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- Question:
  - Does the prior authorization process expedite payment?
- Answer:
  - A provisional affirmed decision notification advises the supplier that Medicare is likely to pay for a specified number of services for a specific period (as outlined in the decision letter). Claims with a provisional affirmed prior authorization must be billed with the unique tracking number (UTN) and will likely process routinely.
  - If prior authorization is not requested, suppliers should expect to receive additional documentation requests (ADRs) to support each date of service billed for repetitive non-emergency ambulance services.

# Question#4

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- Question:
  - In the event a beneficiary needs more than the 60 days of transport, when can we request the next prior authorization? We would want to make sure the authorization is back before the current authorization expires.
- Answer:
  - To avoid payment interruptions, submit the subsequent prior authorization request no later than 10 business days before the end of the 60-day period. On the cover sheet, in the 'Start Date of Authorization' field, specify the start date of the next period. Ensure that date is after the end of the prior 60-day period.

# Question#5

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- Question:
  - Can we have another supplier perform a transport if authorization is given to us and at times when we are unavailable?
- Answer:
  - Yes, if a supplier does not have a prior authorization, then the supplier would file the claim and a letter requesting additional documentation will be sent for the claim to be medically reviewed before payment.

# Question#6

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- Question:
  - Is the assigned UTN to the beneficiary or the transporter? What if a beneficiary wants to switch suppliers?
- Answer:
  - The assigned UTN is to the beneficiary for transports by one supplier, per requested timeframe.
  - If the beneficiary wants to switch suppliers, then the beneficiary should contact the supplier with the assigned UTN and request the UTN to be expired. The supplier then would call 855-340-5975 and cancel the UTN.
  - If a supplier ceases to transport a beneficiary before the UTN expires, that supplier can call 855-340-5975 and cancel the UTN. Afterwards another supplier can submit a request for prior authorization for the beneficiary.

# Question#7

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- Question:
  - If I submit a detailed and comprehensive PCS that the physician completes, will it alone qualify as sufficient to support medical necessity?
- Answer:
  - No. Medical records from the physician or other certified healthcare professionals that support that PCS must also be submitted.

# Question#8

- Question:
  - What should ambulance suppliers do if the certifying physician will not provide the additional documentation?
- Answer:
  - CMS created an informational letter directed towards physicians that is available for download on the CMS ambulance prior authorization website
  - Ambulance suppliers can give the letter to certifying physicians reminding them of their responsibility to provide the medical record documentation that supports the Physician Certification Statement
  - If the physician and/or facility will still not provide the documentation, ambulance suppliers should notify their MAC or CMS (at AmbulancePA@cms.hhs.gov) of the physicians and/or facilities
  - Physicians and/or facilities who show patterns of non-compliance with this requirement, including those physicians and/or facilities whose records are inadequate or incomplete, may be subject to increased reviews, such as through provider-specific probe reviews

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# References and Prior Authorization Contact Information

# Ambulance References

- Novitas Solutions offers a dedicated resource center for all Ambulance-related resources:
  - Ambulance Prior Authorization Documentation Requirements (JH) (JL)
  - Repetitive Scheduled Non-Emergent Ambulance Transport (JH) (JL)
  - RSNAT PA FAQs (JH) (JL)
  - Provider Specialty-Ambulance (JH) (JL)
- CMS also offers a dedicated resource center:
  - Ambulance Service Center
  - Provider Compliance Tips for Ambulance Services
  - Ambulance Services Internet Only Manual:
    - ✓ IOM 100-2; Medicare Benefit Policy Manual, Chapter 10
    - ✓ IOM 100-4; Medicare Claims Processing Manual, Chapter 15
  - Ambulance Prior Authorization Operational Guide
  - CMS Prior authorization initiatives
  - CMS Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model Frequently Asked Questions
  - National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model

# Prior Authorization Customer Contact Center

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- Suppliers garaged in:
  - Jurisdiction H:
    - ✓ Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma and Texas
  - Jurisdiction L:
    - ✓ Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia
  - 1-855-340-5975
  - Hours of operation:
    - ✓ Monday through Friday 8:00 am – 6:00 pm (ET)

# Summary

NOVITAS SOLUTIONS

- Detailed the changes due to implementing the prior authorization
- Discussed the process for prior authorization
- Covered the ambulance policy and requirements for coverage
- Discussed the common reasons for non-affirmed decisions
- Covered FAQs for RSNAT Prior Authorization
- Provided references, contact information and update

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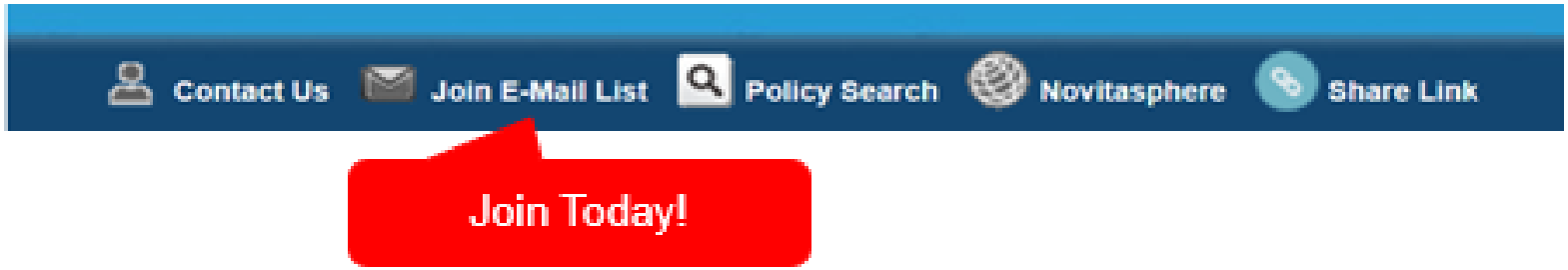


- Receive current updates directly via email:
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  - Issued every Tuesday and Friday
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
  - Click the Join E-Mail List (JH) (JL) from our website tool bar
- Didn't receive verification or stopped receiving email notifications?
  - Follow these simple steps to allow emails

# Thank You


- Gail Atnip
  Education Specialist, Provider Outreach and Education
  Gail.Atnip@novitas-solutions.com
  214-356-4210