Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport

The attached **"Important Message from Medicare"** will be mailed to Medicare Beneficiaries, informing them that Medicare will expand the prior authorization demonstration program for repetitive, schedule non-emergency ambulance transportation in their area on January 1, 2016, when our records show they have received repetitive ambulance services in the past.

An Important Message from Medicare:

This notice is to inform you that Medicare will expand the prior authorization demonstration program for repetitive, scheduled non-emergency ambulance transportation to your area on January 1, 2016. According to our records, you have received repetitive ambulance services in the past.

Repetitive ambulance services means you get 3 or more round trips in a 10-day period or at least one round trip per week for 3 weeks or more. Prior authorization means Medicare will review medical documents to make sure you meet Medicare's coverage requirements for the repetitive transportation services you need.

If you continue to receive these services on or after January 1, 2016, Medicare will use a prior authorization process to make sure you meet Medicare's coverage requirements for repetitive, scheduled non-emergency ambulance transportation services.

What do I need to do?
You or your ambulance company may submit a prior authorization request under this program. The Medicare contractor will review the prior authorization request to determine if you meet Medicare's coverage requirements for the ambulance transportation. You will receive a letter generally within 10-20 business days informing you if your request was approved.

What if my request is not approved?
If your request is not approved and you have additional information that supports your need for repetitive, scheduled non-emergency ambulance transportation, either you or your ambulance company may submit another prior authorization request with the necessary documents to the Medicare contractor.

What if my request is not approved and I continue receiving ambulance transport?
Medicare does not cover non-emergency ambulance transport services that do not meet all coverage requirements, including medical necessity. If your request is not approved and you continue receiving these services, the ambulance company may submit the claim to Medicare and bill you for all denied charges even if you did not sign an Advance Beneficiary Notice of Noncoverage (ABN). You or your ambulance company may also appeal the denied claim.

Are my benefits changing?
No. Your Medicare ambulance benefit is not changing. Medicare will continue to cover non-emergency ambulance transportation if, in addition to meeting other coverage requirements, one of the following medical necessity requirements applies to you:

- You are confined to a bed, and it is documented that due to your medical condition, other methods of transportation would endanger your health; OR
- Ambulance transportation is medically required due to your medical condition, regardless of bed confinement.

Who can I contact if I need help?
There are state and local services that may help you with your transportation needs. If you need assistance finding other transportation services, please contact Eldercare at 1.800.677.1116 or your local State Health Insurance Assistance Program (SHIP). To get the phone number for the SHIP in your state, visit http://www.shiptacenter.org or call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have Medicaid or Programs of All-Inclusive Care for the Elderly (PACE), you may contact those programs to see if you qualify for help with transportation coverage.

If you have additional questions, visit http://www.Medicare.gov or call 1.800.MEDICARE.

The Centers for Medicare & Medicaid Services (CMS) is implementing a prior authorization model for repetitive scheduled non-emergent ambulance transports to test whether prior authorization helps reduce expenditures, while maintaining or improving access to and quality of care. CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

The model began in New Jersey, Pennsylvania, and South Carolina in December 2014. Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) expands the prior authorization of repetitive scheduled non-emergent ambulance transports model effective no later than January 1, 2016 to six additional areas:

- Delaware
- Maryland
- Virginia
- The District of Columbia,
- North Carolina
- West Virginia

The purpose of this model is to test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. Prior authorization will not create new clinical documentation requirements. Instead, it will require the same information necessary to support Medicare payment, just earlier in the process. Prior authorization allows providers and suppliers to address issues with claims prior to rendering services and to avoid an appeal process.

You can find more information on the model by going to: http://go.cms.gov/PAAmbulance

Questions can be sent to: AmbulancePA@cms.hhs.gov

Additional resources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/AmbulancePriorAuthSlides_ODF-111015.pdf

