Oklahoma Ambulance Association: Proposed Guidelines for the Expansion of the Prior Authorization

October 19, 2016

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Agenda

- Background Information
- Unchanged Guidelines
- Changed Guidelines
- Prior Authorization Process
- Non-Affirmed Reasons and Sources
- Updates and Reminders

Objectives

- Cover the Background of the Prior Authorization
- Review the changed and unchanged Ambulance policy
- Review the Prior Authorization Process
- Review the Non-Affirmed Reasons and Sources
- Review important Ambulance updates and reminders

Acronym List

Acronym	Definition
ALS	Advanced Life Support
BLS	Basic Life Support
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
EDI	Electronic Data Interchange
ESRD	End-Stage Renal Disease
HCPCS	Healthcare Common Procedure Coding System
ICD-10-CM	International Classifications of Diseases, Tenth Revision, Clinical Modification
LCD	Local Coverage Determination
MLN	Medicare Learning Network
NPI	National Provider Identifier

Additional Acronyms

Acronym	Definition
PCS	Physician Certification Statement
PTAN	Provider Transaction Access Number
UTN	Unique Tracking Number
ZIP	Zone Improvement Plan

Background Information

Purpose

- CMS established a three-year prior authorization process for repetitive scheduled non-emergent ambulance transports:
  - The prior authorization process is expected to ensure beneficiaries receive medically necessary care and help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid
  - Effective 12/01/14, CMS implemented the prior authorization process in the Jurisdiction L (JL) states of New Jersey and Pennsylvania for dates of service on/after 12/15/14
  - Effective 12/15/15, CMS expanded the prior authorization in the JL states of Delaware, Maryland and the District of Columbia for dates of service on/after 01/01/16

INNOVATION IN ACTION

Medicare Access and CHIP Reauthorization Act of 2015

- Section 515:
  - National Expansion of Prior Authorization Model for Repetitive Scheduled Non-Emergency Ambulance Transport:
    - ✓ The expansion to all states beginning January 1, 2017
- In order to implement the expansion, CMS will notify the contractors and give guidance:
  - CMS has not given the contractions any information on the expansion
- The guidelines in this presentation are currently being used in the JL states
- Reference:
  - https://www.congress.gov/bill/114th-congress/house-bill/2/text

What is Prior Authorization

- Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is rendered to a beneficiary and before a claim is submitted for payment
- Prior authorization helps ensure that applicable coverage, payment and coding rules are met before services are rendered

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

Who and What

- Ambulance suppliers not institutionally based that provide Part B Medicare-covered ambulance services and are enrolled as independent ambulance suppliers
- Repetitive scheduled non-emergent ambulance transport claims not included in a covered Part A stay:
  - Billed on a CMS 1500 form or the electronic equivalent

Unchanged Guidelines

CMS National Policy

- 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
- Not covered when the patient's condition permits transport in any type of vehicle other than an ambulance
- Payment dependent on patient's condition at actual time of transport regardless of diagnosis
- Patient must require the transportation and level of service provided

Additional CMS National Policy

- Medicare covers both emergency ambulance transportation and non-emergency ambulance transportation based on medical necessity:
  - Patient's condition requires the vehicle itself and/or the specialized services of the trained ambulance personnel
  - The needed services of the ambulance personnel were provided and clear clinical documentation validates medical need and their provision in the record of the service (usually the run sheet)
- Actual transportation of the beneficiary occurs
- Services must be reasonable and necessary
- Transportation is to the closest appropriate facility

Medical Necessity

- Medicare covers ambulance services when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated:
  - 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
  - This usually means that the beneficiary is bed-confined and/or meets the criteria for medical necessity as defined and detailed on the LCD
- The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 C.F.R. §410.40(d)

Medical Necessity and Bed-Confinement

- The definition of bed-confinement:
  - The patient is bed-confined before, during and after transportation; and is:
    - ✓ Unable to get up from bed without assistance
    - ✓ Unable to ambulate, and
    - ✓ Unable to sit in a chair (including a wheelchair)
  - Must meet all three criteria

Coverage and Documentation

- Medicare coverage policies remain unchanged
- Documentation/medical record requirements for medical necessity remain unchanged
- Local Coverage Determination for Ambulance Ground Services L35162:
  - https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?Date=09%2F08%2F2015&SearchType=Advanced&LCDId=35162&ContrId=323&DocID=L35162&bc=KAAAAAgAAAAAAA%3D%3D#main_content

Ambulance Coverage Destinations

- Covered to the following destinations:
  - Hospital
  - Critical Access Hospital (CAH)
  - Skilled Nursing Facility (SNF)
  - Beneficiary's home
  - Dialysis facility for an ESRD patient who requires dialysis
- Nearest appropriate facility
- Mileage to the nearest appropriate facility covered

Appropriate Facilities

- 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

Changed Guidelines

What Has Changed

- The ambulance supplier will know before the service is rendered whether the service is prior-authorized for payment
- The beneficiary will also know before the service is rendered whether the service is prior-authorized for payment

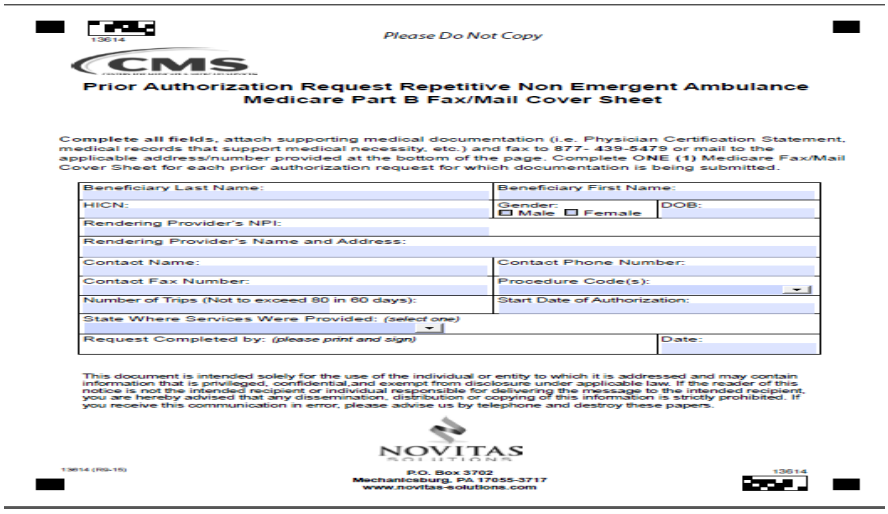
INNOVATION IN ACTION

Prior Authorization Process

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

Prior Authorization Cover Sheet



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CMS

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:	
HICN:	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 80 in 60 days):	Start Date of Authorization:	
State Where Services Were Provided: *(select one)*		
Request Completed by: *(please print and sign)*	Date:	

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I N N O V A T I O N I N A C T I O N

Prior Authorization Cover Sheet Requirements

- Requests need to identify:
  - Beneficiary's first and last name
  - Health Claim Number (HICN)
  - Gender
  - Date of Birth
  - Rendering Providers NPIs:
  - Rendering Provider's Name and Address
  - Contact Name
  - Contact Phone Number
  - Contact Fax Number
  - Procedure Code(s)
  - Number of Trips (not to exceed 80 in 60 days)
  - Start Date of Authorization
  - State Where Ambulances are Garaged
  - Request Completed by
  - Date (of signature)
- http://www.novitas-solutions.com/webcenter/spaces/MedicareJL/page/pagebyid?contentId=00083988

I N N O V A T I O N I N A C T I O N

Additional Required Documentation

- Completed and current Physician Certification Statement (PCS)
- Current medical records to support the medical necessity of repetitive scheduled non-emergent ambulance transport:
  - 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

PCS Specifications: Condition and Signature

- The PCS should contain 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
- The PCS must:
  - Be signed and dated by the patient's attending physician:
    - ✓ The signature and date must be readable:
      - ➢ Credentials next to the signature will facilitate the prior authorization process
      - ➢ The prefix "Dr." is a title and not a credential
    - ✓ Stamped signatures or file signatures are not acceptable

PCS Specifications: Timeframe and Limits

- Timeframes and limitations:
  - The PCS cannot be dated more than 60 days in advance of the requested start date, nor can it be dated after the requested start date:
    - ✓ A PCS signed 11/01/15 would not be valid for a request with a start date of 02/20/16
    - ✓ A PCS signed 01/28/16 is not valid for a 12/15/15 start date
  - What happens if the PCS signature date comes after the requested start date?
    - ✓ If the (current) medical records and the PCS signature date predate the requested start date (on the cover sheet), then the actual start date will be as requested
    - ✓ If the medical records or the PCS signature date are after the requested start date, then the actual start date will be either the date on the PCS or the date of service within the documentation that supports the medical necessity of the transports

Medical Records

- A signed and dated PCS or supplementary form does not, by itself, demonstrate that the repetitive scheduled transports are medically necessary
- A signed and dated attestation letter (prepared statement) alone cannot support medical necessity
- Medical records should provide sufficient information to support the PCS

LCD on Medical Record Specifications

- 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
  - All documentation must be maintained in the patient's medical record and be available to the contractor upon request

LCD on Record Legibility and Contents

- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s))
- The record must include the physician or non-physician practitioner responsible for and providing the care of the patient
- The submitted medical record must support the use of the selected ICD-10-CM code(s)
- The submitted CPT/HCPCS code must describe the service performed
- Medical records should:
  - Capture the beneficiary's condition(s) that necessitate(s) the transports:
    - ✓ Reveal the medical necessity of the type and level of transport services
  - Support the diagnoses or the ICD-10-CM code(s) on the PCS with clinical assessment data and objective findings

Sources of Medical Records

- The medical records submitted can include, but are not limited to:
  - Doctor's progress notes
  - Nursing notes
  - History and Physical:
    - ✓ Physical or occupational therapy notes
    - ✓ Admission and discharge summaries

Supporting the PCS

- For a condition itemized on the PCS, the medical records must contain statements that capture the "what" and the "why":
  - The "what" is a statement of the mobility status issue and/or condition:
    - ✓ "Patient is bedbound"
  - The "why" is clinical assessment data on the conditions that make up the mobility status issue

Documentation is Insufficient …

- The top reasons the medical record proves to be insufficient are:
  - The records have data that contradicts the PCS
  - The records have data that contradicts other data therein
  - The records lack clinical assessment data that comprehensively captures the mobility status/condition

Prior Authorization Request Submission

- The ambulance supplier or the beneficiary may submit the request
- The request can be:
  - Mailed:
    - ✓ Address will be published once we receive notice from CMS to implement the process
  - Faxed:
    - ✓ Number will be published once we receive notice from CMS to implement the process
  - Electronic Submission of Medical Documentation (esMD) system:
    - ✓ Indicate document type "81"
    - ✓ http://gocms.gov/esMD

Number of Trips

- The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips (which equates to 80 transports) per prior authorization request in a 60-day period
- A provisional affirmed prior authorization decision may affirm less than 40 round trips, or affirm a request that seeks to provide a specified number of transports (40 round trips or less) in a less than 60-day period:
  - An affirmed decision can be for all or part of the requested number of trips
- Transports exceeding 40 round trips (or 80 transports) in a 60-day period require an additional prior authorization request

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 20 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 will be provided on the decision letter
- 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

- 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 prepayment medical review
- Novitas could conduct prepayment reviews on ambulance claims for any beneficiary determined to be a recipient of repetitive services:
  - If you are subject to prepayment review, the most efficient method is to send in one package at a time

Non-Affirmed

- When a prior authorization is submitted but non-affirmed, the submitter can:
  1. 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, and the PCS and the medical records must be valid for the requested timeframe
  2. Provide the service and submit a claim:
     - ✓ If billed correctly with the non-affirmed UTN, the claim will process normally and be denied
     - ✓ All appeal rights are available for the claim denial
     - ✓ If you appeal denied claims, the most efficient method is to fax in one claim at a time

Exclusions

- Ambulance suppliers under review by a Zone Program Integrity Contractor (ZPIC) are not eligible to submit prior authorization requests
- When the program began, Medicare beneficiaries who had legal representative payees on file through the Social Security Administration (SSA) were excluded from the prior authorization process:
  - Beginning with dates of service on or after 04/01/16, beneficiaries with a representative payee are now included in the repetitive scheduled non-emergent ambulance transportation services prior authorization program

Not Using the Prior Authorization Process

- If an ambulance supplier has not requested prior authorization before the fourth round trip:
  - The subsequent claims will be subject to prepayment review
  - An Additional Development Request (ADR) letter will be sent
  - Submitted medical records will be reviewed within **30 calendar** days
- Without a prior authorization decision, the supplier or the beneficiary will not know if the service meets the criteria for payment

Beneficiary Impacts

- Service benefit is not changing
- Beneficiaries will receive a notification of the decision about their prior authorization request
- Dual eligible coverage is not changing
- Private insurance coverage is not changing

Non-Affirmed Reasons and Sources

INNOVATION IN ACTION

The PCS Must Be Signed by the Attending Physician

- Reason (A): PCS was signed by a provider other than the attending physician:
  - LCD L35162: "For scheduled and non-scheduled non-emergency ambulance transports, providers of ambulance transportation must obtain a written statement PCS from the patient's attending physician certifying that medical necessity requirements for ambulance transportation are met. … Repetitive non-emergency scheduled transports must be signed by the attending physician."
  - 42 CFR 410.40(a)(2): "Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met."

PCS Signature Date

- Reason (B): The PCS is dated more than 60 days before the date of the requested ambulance transport and is not a valid PCS:
  - 42 CFR 410.40(a)(2): "The physician's order must be dated no earlier than 60 days before the date the service is furnished."
  - LCD L35162: "The PCS must be dated no earlier than 60 days in advance of the transport for those patients who require repetitive ambulance services and whose transportation is scheduled in advance."
- Reason (C): The PCS is missing the date that it was signed by the physician:
  - LCD L35162: "Signatures on the PCS must be dated at the time they are completed."

PCS Legibility

- Reason (D): A portion of the documentation on the PCS is not readable (legible):
  - LCD L35162: “Every page of the record must be legible.” … “Documentation must be legible.”
- Reason (E): The signature on the PCS is not readable (legible) and there is no typed or printed name on the PCS:
  - LCD L35162: “The signature of the medical professional completing the PCS must be legible (or accompanied by a typed or printed name) and include credentials.” … “The documentation must include the legible signature of the physician.”

Medical Record Legibility

- Reason (F): The medical record submitted on (Page #) is not readable (legible):
  - LCD L35162: “Every page of the record must be legible.”
- Reason (G): There is no readable (legible) physician and/or practitioner signature on (the record) submitted for review:
  - LCD L35162: “The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.”
  - See Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions (3.3.2.4 and 3.3.2.5).

Date of Service of the Medical Record

- Reason (H): The medical documentation received for review is not considered current medical records:
  - LCD 35162: “Having or having had a serious illness, injury or surgery does not necessarily justify Medicare payment for ambulance transportation, thus a thorough assessment and documented description of the patient’s current state is essential for coverage.”
- Reason (I): There is no identifiable date of service on the medical records:
  - LCD 35162: “Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.”

Origin and Destination Address Missing

- Reason (J): 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:
  - LCD 35162: Documentation Requirements … “6. Point of pick-up/destination (identify place and complete address).”
  - Repetitive Scheduled Non-Emergent Ambulance Transport Model Operational Guide: “Additional Required Documentation: … Information on the origin and destination of the transports.”

Transports not Necessary for Treatment

- Reason (K): 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):
  - LCD L35162: "Non-emergency ambulance transportation is not covered if transportation is provided for the patient who is transported to receive a service that could have been safely and effectively provided in the point of origin (residence, SNF, hospital, etc.). Such transportation is not covered even if the patient could only have gone for the service by ambulance."

Covered Destinations

- Reason (L): The ending location (destination) of the requested non-emergency transport is not covered under Medicare non-emergency ambulance transport guidelines:
  - LCD L35162: "Covered destinations for "non-emergency" transports include:
    - ✓ Hospitals ("appropriate facility")
    - ✓ SNF
    - ✓ Dialysis facilities – Ambulance services furnished to a maintenance dialysis patient only when the patient's condition at the time of transport requires ambulance services
    - ✓ From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip (for instance, cardiac catheterization; specialized diagnostic imaging procedures such as computerized axial tomography or magnetic resonance imaging; surgery performed in an operating room; specialized wound care; cancer treatments) when the patient's condition at the time of transport requires ambulance services
    - ✓ The patient's residence only if the transport is to return from an "appropriate facility" and the patient's condition at the time of transport requires ambulance services."

Letters, Trip Sheets, and Statements

- Reason (M): Ambulance trip reports/run sheets are not acceptable as the only … medical records for Prior Authorization. Review of the request cannot be completed without additional medical records:
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.1 (B) - Documents on Which to Base a Determination: "Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the signed by the (sic) ordering physician.":
  - See LCD L35162 for the ten "Documentation Requirements"

Physician Attestation and Signature Attestation Statements

- Reason (N): Attestation letters for medical necessity from healthcare providers are not acceptable as the only … medical records. Review of the request cannot be completed without additional medical records:
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.1.1(B): "Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the ordering physician."
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.4(C): "The MACs and CERT shall NOT consider (signature) attestation statements where there is no associated medical record entry."

Patient Letters

- Reason (O): Letters from the patient and/or relatives are not medical records. Review of the request cannot be completed without medical records:
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.1.1(B): ""Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the ordering physician."
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.1: "For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary's medical documentation and confirm that Medicare coverage criteria have been met."

Identifying Information Missing, Contradictory

- Reason (P): The patient's identifying information on the PCS is incomplete or does not match our records
- Reason (Q): The patient's identifying information (i.e. name, date of birth, or Healthcare Identification Number) on the PCS does not match the information on (the medical records)
- Reason (R): The medical record(s) is/are missing the patient's name/identifying information:
  - LCD L35162: "Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient."
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.4(I): "Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation."

Medical Records Conflict

- Reason (S): … conflicting information:
  - 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:
    - ✓ LCD L35162: "It is important to note that the mere presence of the signed physician certification statement 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."
    - ✓ LCD L35162: "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. … Coverage will not be allowed if the trip record contains an insufficient description of the patient's condition at the time of transfer for Medicare to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the patient's condition is limited to conclusory statements and/or opinions."
    - ✓ Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.1: "For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary's medical documentation and confirm that Medicare coverage criteria have been met."

Medical Necessity Unsupported by Records

- Reason (T): 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
- Reason (U): The medical records received were insufficient to support non-emergency ambulance transport as medically reasonable or necessary:
  - LCD L35162: "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. … Coverage will not be allowed if the trip record contains an insufficient description of the patient's condition at the time of transfer for Medicare to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the patient's condition is limited to conclusory statements and/or opinions."
  - Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, 3.3.2.1: "For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary's medical documentation and confirm that Medicare coverage criteria have been met."

Beneficiary May Not Qualify for the Benefit

- Reason (V): 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
- Reason (W): 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:
  - LCD L35162: "Medicare covers ambulance services 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." … "To be deemed medically necessary for payment, the patient must require both the transportation and the level of service provided."
  - 42 CFR Ch. IV (10–1–02 Edition): "Medicare covers ambulance services … only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary."

Updates and Reminders

Ambulance Transports Require Dual Diagnoses

- All ground ambulance transports require dual diagnoses for services rendered October 1, 2015 and after:
  - Providers should report the most appropriate ICD-10-CM code that adequately describes the patient's medical condition at the time of transport as the primary diagnosis
- One diagnosis from the ambulance article or a valid ICD-10-CM Code from the ICD-10-CM manual:
  - LCA– Ground Ambulance Services – A54574
- A secondary diagnosis must be reported from the LCD:
  - LCD- Ground Ambulance Services - L35162
- Reference:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00024343

Frequently Asked Questions (FAQ) #1, #2 and # 3

- Question:
  - What if a secondary code from the LCD list does not get reported on the claim?
- Answer:
  - It will deny
- Question:
  - How will the claim be processed if a diagnosis is used from the ICD-10 manual that is not listed in the Article?
- Answer:
  - The ICD-10 code from the manual will be considered
- Question:
  - Does it matter which code is submitted first the article code/ICD-10 manual code or the LCD Code?
- Answer:
  - No order is required as long as one code from the LCD and one code from the article codes/ICD-10 manual codes are submitted

Frequently Asked Questions (FAQ) #4 and #5

- Question:
  - Can more than one of the secondary codes listed in the LCD be submitted on the claim?
- Answer:
  - We recommend only using one of the secondary codes from the LCD
- Question:
  - What if the claim is filed with the GY modifier and the code Z76.89 is not submitted on the claim?
- Answer:
  - The claim will deny

Frequently Asked Questions (FAQ) #6 and #7

- Question:
  - When filing a claim for an Aid Call is one of the secondary codes listed in the LCD required?
- Answer:
  - No, only an ICD-10 code from the Ambulance article or ICD-10 code from the manual is required
- Question:
  - When filing a claim with the QL modifier is one of the secondary codes listed in the LCD required?
- Answer:
  - No, only an ICD-10 code from the Ambulance article or ICD-10 code from the manual is required

Claims that are Denied

- To correct any initial submissions:
  - Resubmit the claim:
    - ✓ Ensure that you report the primary diagnosis code as the most appropriate ICD-10 code that adequately describes the patient's medical condition at the time of transport. In addition, a secondary diagnosis code must be reported, which reflects the patient's need for the ambulance service and ambulance personnel at the time of transport
  - Request a reopening of the claim:
    - ✓ Use the Medicare Redetermination and Clerical Error Reopening Request Form
    - ✓ Include a revised copy of the claim highlighting the service in question and include the appropriate primary and secondary ICD-10 code:
      - ➢ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00088692
  - Claim corrections can also be submitted electronically via Novitasphere:
    - ✓ Diagnosis code
    - ✓ Modifiers

Novitas Ambulance Mileage Edits

- Novitas began suspending claims received on March 15, 2016 for ambulance mileage billed with a Q/B (Quantity Billed) of 126 or greater:
  - Mileage codes A0425, A0435, and A0436
  - Ambulance claims that do not include sufficient justification/documentation will receive an ADR (Additional Documentation Request)
  - Documentation may be submitted in the:
    - ✓ Appropriate electronic fields
    - ✓ Freeform fields
    - ✓ Claim notes or other forms of documentation
    - ✓ At the time of submission, letter requesting the necessary information/documentation to support the mileage billed beyond 126 miles
- Due to the limited space on the CMS-1500 claim form, supporting documentation may need to be included/attached at the time of submission

Submitting Supporting Mileage Documentation

- To submit additional documentation for an electronic claim, follow the instructions provided in the:
  - Electronic Billing Guide: Chapter 11 – Submitting Medical Documentation for Part A/B 5010 Electronic Claims:
    - ✓ http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00004552
- Failure to return information requested in an ADR will result in denial of the line item detail with:
  - CARC (Claim Adjustment Reason Code) 50 and
  - RARC (Remittance Advice Remark Code) N102
- If your claim denies, you have the right to appeal the decision along with documentation/justification for mileage billed beyond 126 miles
- Reference:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00121964

Ambulance Payment Extended

- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended payment provisions of previous legislation
- Section 203 extends the provision:
  - Increasing Ambulance Fee Schedule amounts as defined by the zip code of the point of pickup:
    - ✓ By 2% for services originating in urban areas
    - ✓ By 3% for services originating in rural areas
  - Relating to payment for ground ambulance services that increased the base rate for transports:
    - ✓ Originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the “super rural” bonus)
  - This provision will expire on December 31, 2017
- Reference:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html

Ambulance Staffing Requirements

- Change Request # 9761:
  - Effective: January 1, 2016
  - Implementation: December 12, 2016
- Key Points:
  - Revisions to the ambulance staffing requirements (80 FR 71078-71080)
  - Provides clarifications on the definitions for ground ambulance services:
    - ✓ ALS Level 1
    - ✓ ALS assessment
    - ✓ Application for ALS, Level 2 (ALS2)
    - ✓ Specialty Care Transport (SCT)
    - ✓ Paramedic Intercept (PI),
    - ✓ Emergency response and
    - ✓ Inter-facility transportation
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9761.pdf

CMS Provider Compliance: ALS Services

- Insufficient Documentation:
  - Ambulance suppliers often submit Medicare claims for ALS ambulance services which lack sufficient medical record documentation
  - The 2015 CERT report states that the improper payment rate for ALS services was 14.5 percent with improper payments projected at $226 million
  - The most frequent errors occur when documentation:
    - ✓ Does not support the medical necessity of the ALS level of service
    - ✓ Lacks the patient's signature authorizing the supplier to bill Medicare for the service

Resources for ALS Services

- Use the following resources to avoid documentation errors:
  - Medicare Ambulance Transports Booklet:
    - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
  - 42 Code of Federal Regulations 424.36 - Signature Requirements:
    - ✓ https://www.gpo.gov/fdsys/granule/CFR-2012-title42-vol3/CFR-2012-title42-vol3-sec424-36/content-detail.html
  - April 2016 Medicare Quarterly Provider Compliance Newsletter:
    - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN909309.pdf
  - Ambulance Fee Schedule Fact Sheet:
    - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbulanceFeeSched_508.pdf
  - Medicare Claims Processing Manual, Chapter 15:
    - ✓ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf

Ambulance Enrollment Moratoria

- CMS extends, expands fraud-fighting temporary moratoria statewide:
  - MACs shall process newly enrolling Part B emergency ambulance suppliers in the high risk category and perform all required screening and related activities for all previous moratoria areas, including Houston, TX
- Reference:
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentMoratorium.html

Provider Enrollment Revalidations – Cycle 2

- Special Edition Article SE 1605
- Key Points:
  - Resumed March 2016
  - CMS has established dates by which providers/suppliers must revalidate
  - Due dates are on the last day of the month (e.g., June 30, July 31, August 30)
  - Provider/supplier due dates will generally remain the same for subsequent revalidation cycles
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1605.pdf

Due Dates for Revalidations

- Due dates posted to CMS.gov Lookup Tool:
  - https://data.cms.gov/revalidation
  - Providers may use the search feature to locate their due date
  - If provider is unable to locate contact CMS via email:
    - ✓ providerenrollment@cms.hhs.gov.
- Due date:
  - "TBD" (To be determined):
    - ✓ One example- provider revalidated in 2015 therefore they do not need to revalidate in cycle 2, this provider will have a TBD
    - ✓ If a TBD appears, providers do not need to submit a revalidation, if they do it will be returned
  - Posted up to 6 months before revalidation due date
  - Updates will be at the beginning of each month
  - Includes crosswalk to reassignment information
- PECOS:
  - Will be updated to reflect if a revalidation is required

Revalidation Notices

- Novitas will continue to issue revalidation notices in addition to the posted list
- Notices will be issued within 2-3 months of your established due date
- Mailing will be at least 2 of your reported addresses:
  - Correspondence
  - Special payments and/or
  - Your primary practice address
- If you are within 2 months of your listed due date but have not received a notice from Novitas to revalidate, you are encouraged to submit your revalidation application

Unsolicited Revalidations

- Unsolicited revalidation applications defined as:
  - Revalidation applications submitted more than 6 months in advance of due date
  - Mailed letter not received from Novitas requesting you to revalidate
  - Do not submit a revalidation application if there is NOT a listed due date
  - All unsolicited revalidation applications will be returned
- If your intention is to submit a change to your provider enrollment record, submit a 'change of information' application using PECOS or the appropriate CMS-855 form

Deactivations

- Avoid deactivation by submitting a complete application to Novitas:
  - Include all active practice locations and reassignments by your requested due date
- Respond to all development requests from Novitas within 30 days of receipt
- Failure to take these actions could result in a hold on your Medicare payments and possible deactivation of your Medicare billing privileges

Reactivation

- Deactivated providers/suppliers are required to submit a complete enrollment application to reactivate
- The provider/supplier will maintain their original PTAN, but will not be paid for services rendered during the period of deactivation (resulting in a gap in reimbursement)
- The reactivation date is based on the receipt date of the new application
- You cannot retroactively bill for services provided while you were deactivated

Enrollment Application Fees

- Ambulance suppliers initially enrolling in Medicare, adding a practice location or revalidating their enrollment information must submit with their application:
  - Proof of payment of the application fee in an amount prescribed by CMS and/or
  - A request for a hardship exception to the application fee
- This requirement applies to applications that Medicare contractors receive on or after March 25, 2011
- The application fee for 2016 is $554
- Payment of the application fee can be made through:
  - Intra-Government Payment and Collection System (IPAC)
  - PECOS on-line application fee payment system

Strengthening Provider and Supplier Enrollment Screening

- CMS is strongly committed to protecting the integrity of the Medicare program and making sure only qualified providers and suppliers are enrolled
- CMS has implemented four tactics to reinforce provider and supplier screening activities:
  - Increase the number of site visits to Medicare-enrolled providers and suppliers
  - Enhance address verification software in the PECOS system to better detect vacant or invalid addresses or commercial mail reporting agencies
  - Deactivate providers and suppliers that have not billed Medicare in the last 13 months
  - Monitor and identify potentially invalid addresses on a monthly basis through additional data analysis by checking against the U.S. Postal Service address verification database
- If you are a provider or supplier, you can help us protect the integrity of the Medicare program by informing us promptly of any changes to your enrollment, as required
- Reference:
  - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-22-3.html

Site Visits Required

- Site visits are conducted by MSM Security, LLC who also sub-contracts with Computer Evidence Specialists, LLC and Health Integrity, LLC
- Site visits are required for:
  - Moderate level of categorical screening:
    - ✓ Ambulance service providers
    - ✓ Community mental health centers
    - ✓ Comprehensive outpatient rehabilitation facilities
    - ✓ Hospice organizations
    - ✓ Independent clinical laboratories
    - ✓ Independent diagnostic testing facilities
    - ✓ Physical therapists enrolling as individuals or as group practices
    - ✓ Portable x-ray suppliers
    - ✓ Revalidating home health agencies
    - ✓ Revalidating DMEPOS suppliers
  - High level of categorical screening:
    - ✓ Newly enrolling DMEPOS suppliers
    - ✓ Newly enrolling HHAs
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1520.pdf

National Site Visit (NSV) Verification Initiative

- Special Edition Article SE1520
- Key Points:
  - National Site Visit Contractor (NSVC) will conduct unannounced site visits:
    - ✓ Observational site visit or
    - ✓ Detailed review
  - Verify site visit through Novitas Enrollment
  - Verify inspector through NSVC:
    - ✓ 1-855-220-1071
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1520.pdf

Processing Timeframes- Paper Applications

- Initial Enrollments, Revalidations and Reactivations:
  - 60-210 calendar days from receipt
  - 80% of applications will be processed within 60-80 calendar days
- Reassignments/Change Requests:
  - 60-120 calendar days from receipt
  - 80% of applications will be processed within 60 calendar days
- Processing timeframes will vary contingent upon the number of development requests and whether or not a site visit is required:
  - To help avoid delays ensure all sections of the enrollment applications are completed and any supporting documentation is provided

Processing timelines- Internet-based PECOS Applications

- Initial Enrollments, Revalidation, Reactivations:
  - 45-120 calendar days from receipt
  - 80% of applications will be processed within 45-80 calendar days
- Reassignments and Change Requests:
  - 45-90 calendar days from receipt
  - 90% of applications will be processed within 45 calendar days
- Processing timeframes will vary contingent upon the number of development requests and whether or not a site visit is required:
  - To help avoid delays ensure all sections of the enrollment applications are completed and any supporting documentation is provided

Timely Reporting of Provider Enrollment Information Changes

- Special Edition Article SE1617
- Key Points:
  - All physician and non-physician practitioners and physician and non-physician organizations must report the following changes within 30 days:
    - ✓ A change of ownership
    - ✓ An adverse legal action
    - ✓ A change in practice location
  - All other changes must be reported to your MAC within 90 days of the change
  - Changes can be reported via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or the CMS 855 paper enrollment application
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1617.pdf

Novitasphere

- Free Web-based portal
- Part B - Access to Eligibility, Claim Information and Remittance Advice, Claim Submission with File Status, Electronic Remittance Advice (ERA), Claim Correction, Secure Messaging and a MailBox
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
  - http://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH/

Novitasphere Claim Correction Feature

- Common clerical errors can be corrected on finalized claims:
  - Number of services or units
  - Diagnosis code
  - Eligible modifiers
  - Procedure code
  - Date of service
  - Place of service
  - Billed amount
- Novitasphere Claims Correction Guide:
  - http://novitas-solutions.com/cs/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00086496&allowInterrupt=1

Novitas Resources and References

- Novitas Solution website:
  - Ambulance Specialty Page:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00134575
  - Ambulance Prior Authorization:
    - ✓ http://www.novitas-solutions.com/webcenter/spaces/MedicareJL/page/pagebyid?contentId=00083990
    - ✓ Documentation Requirements:
      - ➢ http://www.novitas-solutions.com:80/webcenter/spaces/MedicareJL/page/pagebyid?contentId=00085628
  - Local Coverage Determination (LCD): Ambulance (Ground) Services (L35162):
    - ✓ https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?Date=09%2f08%2f2015&SearchType=Advanced&LCDId=35162&ContrId=323&DocID=L35162&bc=KAAAAAgAAAAAAA%3d%3d#main_content

CMS References

- Prior authorization initiatives:
  - http://go.cms.gov/PAAmbulance
- Ambulance Prior Authorization Operational Guide:
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/AmbulancePriorAuth_OperationalGuide_110714.pdf
- Special Edition SE 1514:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1514.pdf
- Ambulance Service Center:
  - http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html
- Ambulance services:
  - IOM 100-2; Medicare Benefit Policy Manual, Chapter 10:
    - ✓ http://www.cms.gov/manuals/Downloads/bp102c10.pdf
  - IOM 100-4; Medicare Claims Processing Manual, Chapter 15:
    - ✓ http://www.cms.gov/manuals/downloads/clm104c15.pdf

Thank you for attending

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