CMS to Expand Prior Authorization for Non-Emergency, Repetitive Ambulance Transports Nationwide

On September 22, 2020, CMS announced that the current prior authorization process for non-emergency, repetitive ambulance transports will be expanded nationwide in the near future. Although an exact date was not given, CMS stated that the current program has reduced Medicare spending by 60% in the model states.

In December 2014, CMS introduced the model program in selected states, New Jersey, Pennsylvania, & South Carolina. In January 2016, CMS added five more states to the program, Delaware, Maryland, North Carolina, Virginia & West Virginia, & the District of Columbia. The program has run on a year-to-year basis for these states & was set to expire on December 1. **The announcement yesterday indicated that the program would continue beyond December 1 for those states & would be announcing future plans to expand the program nationwide.**

Non-Emergency, Repetitive Transports are defined as 1 non-emergency ambulance transport per week for 3 weeks or 3 transports in a 10-day period. The process requires the EMS Agency to obtain prior authorization for these transports through the Medicare Administrative Contractor (MAC). **The prior authorization process requires submission of a valid PCS form, signed by the attending physician, as well as the patient's medical records that validate the medical necessity of non-emergency ambulance transportation.** In most cases, a letter written by the attending physician is not valid by itself to represent medical necessity.

In the Model States, the prior authorization process takes approximately 10 days to receive the affirmation of coverage. If the request is denied, an appeal can be submitted with additional documentation. Medicare will cover the first three ambulance transports while the agency is obtaining the prior authorization affirmation.

EMS|MC supports this program & feels that it is in the best interest of the EMS Agency as long as documentation can be obtained from the attending physician & facilities. **Advantages to the program include allowing the MAC to determine medical necessity either prior to or shortly after the agency begins transporting an individual.** If the MAC deems the transport not medically necessary, the agency has the opportunity to arrange for alternative transportation for the patient without racking up in some cases hundreds of thousands of dollars in charges that might be recouped later in post-payment reviews.

While these claims could be audited at a later date, the prior authorization obtained by the MAC dramatically decreases the risk for an agency to be audited in the future & required to refund to Medicare those dollars paid for not medically necessary transports that may include extrapolation.

For those agencies not yet participating in this program, now is the time to develop a relationship with the facilities to educate them on your need to access patient medical records for future prior authorization requests. These facilities are allowed to release these medical records under HIPAA as it pertains to payment for your organization. In fact, CMS has released a letter that can be provided to the facilities & attending physicians that explains the program & reiterates their need to share these medical records with your agency.

EMS|MC has extensive experience in processing claims under the Prior Authorization model & will be assist your agency in developing standard policies & procedures for implementing this policy in your organization.

The CMS document can be found here.

If you have any further questions, send an e-mail to advocacy@emsbilling.com or reach out to your Strategic Account Manager.