The Medicare Non-Emergency Prior Authorization Program:

Setting Yourself Up for Success
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THE MEDICARE NON-EMERGENCY PRIOR AUTHORIZATION PROGRAM: SETTING YOURSELF UP FOR SUCCESS

abc360 Compliance Sessions

It’s Coming

- Started in 3 states (PA, NJ, SC)
- December 2014
- Expanded in January 2016 to DE, DC, MD, VA, WV, NC
- Beginning January 1, 2017 the program will operate nationwide:
  - All states and territories
  - All MACs will be involved

The Exceptions

- Does not apply to:
  - Hospital-based providers
  - Ambulance suppliers under ZPIC review
  - Non-covered claims submitted with GY
  - Beneficiaries with a “Legal Representative Payee” on file through the Social Security Administration

The Exceptions

- Alert from Novitas Jurisdiction JL (DC, DE, MD, NJ, PA) changes things
- Representative payee will be included

It is “Voluntary”

- You can choose not to request prior authorization
  - All repetitive transports will be subject to pre-payment medical review
  - You have to wait to get paid, but a different team at the MAC is responsible for review

So, when they say it’s “voluntary”…

It all weighs in favor of obtaining prior authorization for your repetitive patient transports
Pre-Payment Review

- Pre-payment review will go through normal channels:
  - Additional Documentation Request ("ADR") from MAC
  - 45 days for ambulance supplier to respond
  - 60 days for MAC to review

The Process

How it Works

- Ambulance service submits information or
- Beneficiary can submit the prior authorization request directly

Prior Authorization Decision

- MAC issues a tracking #
  - "Affirmation" (approval)
  - "Non-affirmation" (denial)
- Notification to supplier and beneficiary

Prior Authorization Denial

- A “non-affirmative” (denial) decision will be issued for:
  - Incomplete submission
  - Medical necessity not met
- You cannot appeal a non-affirmative decision, but you can resubmit the request (unlimited tries)

Prior Authorization Approval

- The “affirmation” (approval) is provisional
  - The future claims “likely” meet Medicare coverage criteria
  - An approved tracking number is not a guarantee of payment
  - Claims that are denied will follow the standard appeals process
## Prior Authorization Approval

- Claims that have an affirmed prior authorization decision (and are ultimately paid) will likely not be subject to additional review
  - Could be subject to random CERT or targeted MAC pre- or post-payment reviews

## Avoid Denials:
Submit the Right Documentation

## Tracking Number

- Approved tracking number must be used on the claims
  - Triggers a payment
- Denied tracking number can be used to submit the claim
  - Triggers a denial which can then be appealed

## What to Submit

- PCS and any other relevant document that describes the patient’s condition
- Your MAC will provide a list of required documentation
  - Request will be denied if documentation is missing or incomplete

## What to Submit

- MAC is free to solicit additional documentation to clarify contradictions or help determine medical necessity where submitted information is not clear

## PCS Must Be Valid

- Must be signed by attending physician
  - Credentials must be present and legible (Prefix “Dr.” is a title, not a credential)
  - Stamped signatures are unacceptable
- Must be valid (within 60 days prior)
Documentation

• Include medical documentation that describes the beneficiary’s condition
  ▪ Should clearly detail medical necessity and the level of service needed
  ▪ Must show that transportation by other means is contraindicated

Documentation

• Documentation should:
  ▪ Show exact origin and destination addresses
  ▪ Explain “what” and “why” of beneficiary condition
  ▪ Support (not contradict) the PCS

Documentation

• Documentation can include:
  ▪ Progress notes
  ▪ Nursing notes
  ▪ HPI
  ▪ Physical/Occupational therapy notes

Be Careful

• Conflicts and contradictions in the medical records will lead to denials
  ▪ Patient cannot be described as “bed confined” on the PCS, but then be ambulatory at physical therapy

Be Careful

• Of course, the content of other providers’ medical records is beyond the ambulance provider’s control
• However, the ambulance service will have to review the documentation carefully to decide if this is a repetitive patient it wants to accept

Be Careful

• Vague statements such as “bed confined” are insufficient
  ▪ Need to explain why the beneficiary is bed confined (e.g. stroke, muscle deconditioning, recent surgery, genetic disease/disorder, etc.)
Be Careful

- Diagnosis of disease or illness may not be enough without corroborating evidence or statements

Guidance from CMS

- MLN Matters SE1514 contains documentation guidance from CMS
- Includes specific excerpts as “Examples of Documentation that Identifies the ‘What’ and the ‘Why,’” taken from a progress note

What We’ve Learned from the Pilot Program

Not the Best Start

- “Growing pains” for both ambulance suppliers and Medicare MACs
  - Many of kinks were ironed out
  - Still high rate of denials – very few approvals

Not the Best Start

- This is a frustrating process
- Where prior authorizations are denied:
  - Claim can still be submitted with denial tracking number, then appealed

Denials for Incomplete Records

- Significant in the beginning:
  - Minor issues and discrepancies
  - Physician name legibility (despite corroborating documents elsewhere)
  - Corroborating documentation was illegible or did not include pt name (despite other identifying information)
Negative Impact

• Huge impact on cash flow
• Adverse effect on beneficiaries
• Medicare payment delays or no payment at all has caused some ambulance suppliers to go out of business

MSP

• If Medicare is the secondary payer, either:
  ▪ Seek prior authorization, submit claim to primary payer, then bill Medicare if primary denies
  ▪ Skip prior authorization, bill primary, then bill Medicare if primary denies (will be subject to pre-pay review)

ICD-10

• ICD-10 coding requirements will still apply, and are not relaxed for prior authorization situations
  ▪ CMS audit and quality program flexibility initiatives only apply to post-pay reviews

The Blacklist

• Certain beneficiaries can be “blacklisted” from future services
  ▪ Regardless of meeting medical necessity based on documentation, there is a permanent “rejection” of services based on the beneficiary
  ▪ Will apply to all ambulance services

What We Know

• An approved tracking number does not follow the beneficiary – it follows the ambulance service that requested the prior authorization

What if More Than One Ambulance Service Transports the Patient?
What We Have Heard
• If multiple ambulance services transport the same patient, each ambulance service must submit a prior authorization request, BUT
• Only one ambulance service may request prior authorization for a beneficiary for per time period

What We Have Heard
• If the patient switches ambulance suppliers during the scheduled transport period
  • New supplier must seek prior authorization
  • Old supplier must relinquish the approval
  • The claim(s) will undergo complex medical review

What We Have Heard
• If a patient subject to prior authorization requires a non-emergency transport for reasons other than for the type of trip the prior authorization was obtained, the Unique Tracking Number (UTN) may still have to be used on the claim

Strategies for Success

Start Now
• Establish good relationships with physicians and facilities to ensure good, accurate, and complete documentation
  • Start building these relationships now
  • Begin to gather needed information like the physician's NPI

Improve PCS Forms
• Improve the quality of the PCS forms
  • Make sure physicians know the importance of the PCS
  • Educate them on the medical necessity requirements for ambulance and the definition of "bed confined"
  • Make sure they know the importance of PCS forms being consistent with the patient's medical records
Check PCS Processes
• Check your process for obtaining PCS forms
  ▪ Avoid a lapse when the PCS expires
  ▪ Make sure a process is in place to avoid billing for transports that do not have a valid PCS

Involve the Beneficiary
• Consider having beneficiary take active role in prior authorization request
  ▪ Better suited to coordinate with physician and facilities
  ▪ Beneficiary can assist in gathering medical records and documentation

Evaluate Your Repetitive Patients
• Start now - ensure patients meet medical necessity criteria
  ▪ Many repetitive patients need to be transported by ambulance
  ▪ But some can be safely transported by other means- downgrade to wheelchair or stretcher van when possible

Evaluate Your Repetitive Patients
• Regularly evaluate your patients:
  ▪ Review PCRs with a critical eye
  ▪ Stress the importance of complete and accurate documentation that paints a picture of the patient's condition

Evaluate Your Repetitive Patients
• Train crews to notify the proper person when a patient's condition improves or changes
• Train call intake staff to be alert for repetitive patients who use wheelchair vans for other transports

Evaluate Your Repetitive Patients
• Remember, even if you have a 60-day PCS and prior authorization approval, the patient's condition can change within that time period
  ▪ A patient who meets medical necessity this week might not meet it next week
Evaluate Your Repetitive Patients

• Gather additional information about the patient
• Patient mobility assessment
  ▪ Performed by paramedic or nurse who interviews and assesses the patient
  ▪ Focus on activities of daily living

Dealing with Non-Affirmed (Denial) Decisions

Resubmit the Request

• Remember you get unlimited attempts to submit your request so don’t give up too early
  ▪ Get more information to supplement your request
  ▪ Determine source of incomplete or inconsistent documentation and fix it if possible (while being truthful and accurate!)

Dealing with Denied Claims

Appeal Denied Claims

• Different department/reviewers involved
• Able to include PCR and other records not specifically requested (or rejected) at prior authorization level
• Works on a trip-by-trip basis (but consider consolidating large number of denied trips)

Opt Out of Prior Authorization

• Submit to pre-payment review instead
  ▪ Forego the headache of the prior-authorization process
  ▪ Different set of reviewers
  ▪ Subject to appeal rights if denied
  ▪ But you’ll have to wait longer to get paid
Say “No” When You Must

• Know when to stop transporting a beneficiary by ambulance where medical necessity is not met
  ▪ Assist the patient with providing other forms of transport
  ▪ Billing for ambulance transports of a patient who does not meet coverage criteria is not worth the risk!

References

• 79 FR 68271 (11/14/14) (initial announcement)
• CMS Website – “Repetitive Scheduled Non-Emergent Ambulance Transport Model Operational Guide”
• Palmetto GBA website – LCD
• Novitas website

Summary

• Prior Authorization program will be nationwide in 2017
• Submit requests with complete and consistent documentation
• Critically evaluate repetitive patients to ensure medical necessity is met