Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport

1-Year Extension Update 12/4/2017

The Medicare Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transport is being extended in the current model States of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia for one additional year to allow for additional evaluation of the model. The model will now end in all states on December 1, 2018.

In the model States, repetitive, scheduled non-emergent ambulance transport claims with dates of service of December 2, 2017 through December 4, 2017 will not be stopped for prepayment review if prior authorization is not requested before the fourth round trip in a 30-day period; however, providers may request prior authorization for these dates of service. All repetitive, scheduled non-emergent ambulance transports in the model States with a date of service on or after December 5, 2017 must have completed the prior authorization process or the subsequent claims will be stopped for prepayment review if prior authorization has not been requested before the fourth round trip in a 30-day period.

Nationwide Expansion Update 10/21/2016

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) expands the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transport to all states if the model meets certain requirements. The Centers for Medicare & Medicaid Services (CMS) is currently exploring the nationwide expansion to determine if all requirements specified in MACRA have been met.

If expansion occurs, there will be advance notice and training opportunities, as appropriate. CMS will continue to update this website as more information becomes available.

Background

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.

Prior authorization does not create new clinical documentation requirements. Instead, it requires the same information that is already required 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 submitting claims for payment, which has the potential to reduce appeals for claims that may otherwise be denied. This will help ensure that all relevant coverage, coding, and payment requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

Phase I

Ambulance suppliers or beneficiaries began submitting prior authorization requests in South Carolina, New Jersey and Pennsylvania on December 1, 2014, for transports occurring on or after December 15, 2014. All repetitive, scheduled non-emergent ambulance transports in these states with a date of service on or after December 15, 2014, must have completed the prior authorization process or the claims will be stopped for prepayment review if prior authorization has not been requested by the fourth round trip in a 30-day period.

Phase II

Section 515 of MACRA included six additional areas in the model effective no later than January 1, 2016: Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.

Ambulance suppliers or beneficiaries in Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia began submitting prior authorization requests on December 15, 2015, for transports occurring on or after January 1, 2016. All repetitive scheduled non-emergent ambulance transports in these areas with a date of service on or after January 1, 2016, must have completed the prior authorization process or the claims will be stopped for pre-payment review if prior authorization has not been requested by the fourth round trip in a 30-day period.