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PRIOR AUTHORIZATION TRAINING HANDOUTS

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PRIOR AUTHORIZATION HANDOUTS

- ❑ A Prior Authorization Submission Checklist
- ❑ Understanding & Completing the Prior Authorization Form
  - A copy for actual use is not included since the demonstration is a model and is subject to change. A new form should be downloaded from your A/B MAC's website with each submission. Palmetto's form can be found under resources & tips at http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~JM%20Part%20B~Medical%20Review~Ambulance%20Prior%20Auth
- ❑ Prior Authorization PAR Codes
- ❑ Important Dates to Remember
- ❑ Common Phase One Rejection Reasons
- ❑ CMS's Physician Letter
  - Share copies of this letter with physicians if you have difficulty obtaining physician signed medical documentation that supports medical necessity.
- ❑ Page, Wolfberg & Wirth's Sample Physician Certification Statement & Completion Instructions
  - A special thanks to PWW for the use of their sample PCS Form in the handouts, as well as, for making this form available as a download on their website https://www.pwwemslaw.com/sites/default/files/forms/medicare-and-billing-related-forms/pww-model-pcs-version-1.6.pdf

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PRIOR AUTHORIZATION SUBMISSION CHECKLIST

- ❑ The applicable A/B MAC's Prior Authorization Form
- ❑ Physician Certification Statement (PCS) signed by the certifying physician
- ❑ Physician signed medical records/written order from the beneficiary's attending physician certifying medical necessity (documentation of the patient's current medical condition that support the PCS form)
- ❑ Information about the origin (pick-up) and destination (drop-off) of the ambulance transport
- ❑ Any other relevant documentation that may help paint a picture to support medical necessity, such as
  - Recent Patient Care Reports (if applicable)
  - Nursing notes
  - Nursing home records & care plans
  - Facility notes (dialysis, wound care, cancer center)
  - Physical or occupational therapy notes
  - Hospital records

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PRIOR AUTHORIZATION FORM

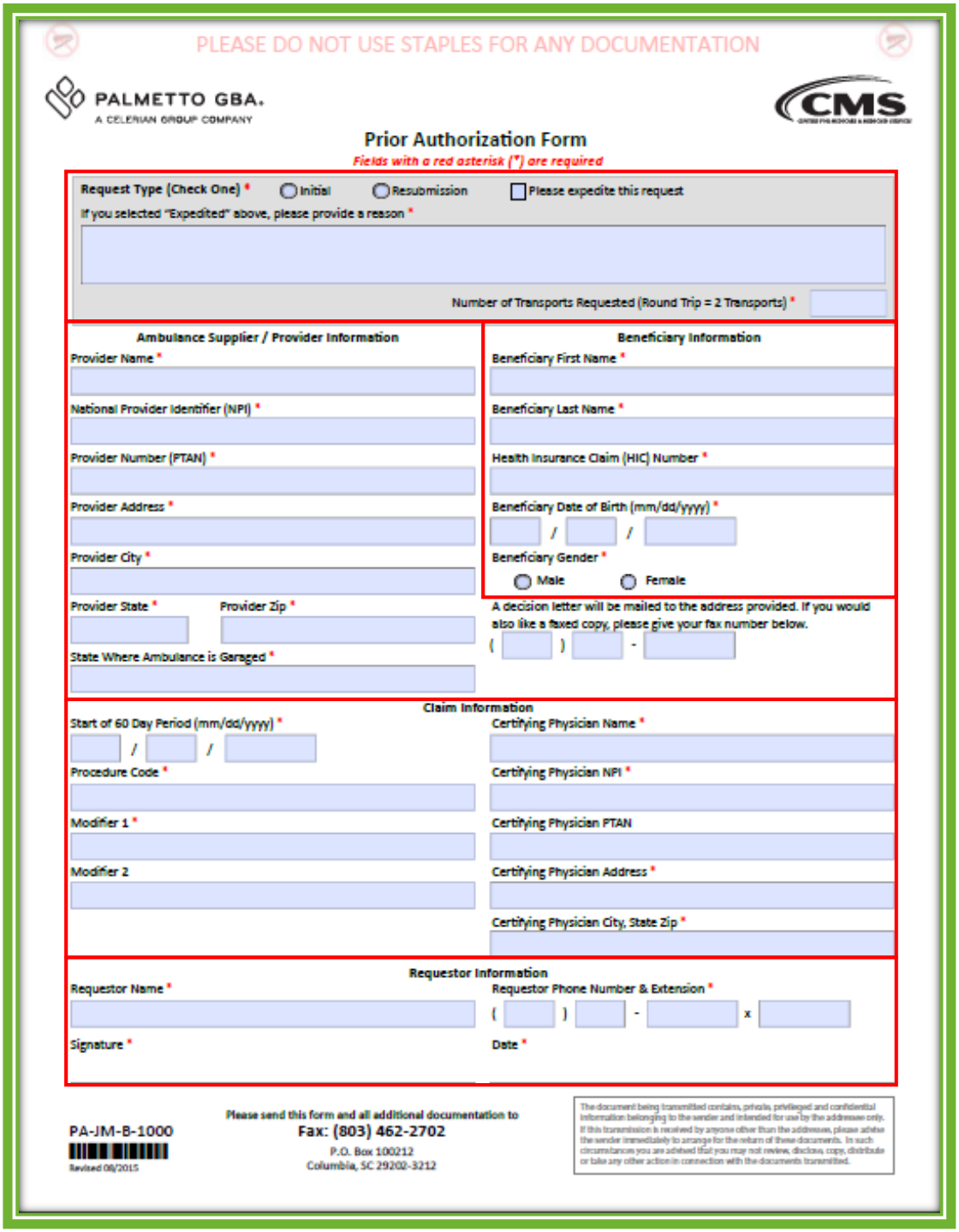
A

B

C

D

E



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

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CMS

Prior Authorization Form

Fields with a red asterisk (*) are required

Request Type (Check One) * ◯ Initial ◯ Resubmission ☐ Please expedite this request

If you selected "Expedited" above, please provide a reason *

Number of Transports Requested (Round Trip = 2 Transports) *

Ambulance Supplier / Provider Information

Provider Name *

National Provider Identifier (NPI) *

Provider Number (PTAN) *

Provider Address *

Provider City *

Provider State * Provider Zip *

State Where Ambulance is Garaged *

Beneficiary Information

Beneficiary First Name *

Beneficiary Last Name *

Health Insurance Claim (HIC) Number *

Beneficiary Date of Birth (mm/dd/yyyy) * / /

Beneficiary Gender * ◯ Male ◯ Female

A decision letter will be mailed to the address provided. If you would also like a faxed copy, please give your fax number below.

( ) -

Claim Information

Start of 60 Day Period (mm/dd/yyyy) * / /

Procedure Code *

Modifier 1 *

Modifier 2

Certifying Physician Name *

Certifying Physician NPI *

Certifying Physician PTAN

Certifying Physician Address *

Certifying Physician City, State Zip *

Requestor Information

Requestor Name *

Requestor Phone Number & Extension * ( ) - x

Signature *

Date *

PA-JM-B-1000
Revised 08/2015

Please send this form and all additional documentation to
Fax: (803) 462-2702
P.O. Box 100212
Columbia, SC 29202-3212

The document being transmitted contains, private, privileged and confidential information belonging to the sender and intended for use by the addressee only. If this transmission is received by anyone other than the addressee, please advise the sender immediately to arrange for the return of these documents. In such circumstances you are advised that you may not review, disclose, copy, distribute or take any other action in connection with the documents transmitted.

https://www4.palmettogba.com/pgx_forms/pdfs/PA-J11-B-1000.pdf

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PRIOR AUTHORIZATION FORM

A: Request Type

- ❑ Choose **either** Initial, Resubmission or Please expedite this request
- ❑ An expedited reason field should **only** be provided when requesting an expedited request. *These requests should be discussed with EMS|MC prior to submitting the request.*
- ❑ Enter the number of transports requested. (Round trip = 2 transports). Calculate the number of trips that your beneficiary will require based on their condition. The maximum number of trips allowed is 80 trips in a 60 day period.

B: Ambulance Supplier / Provider Information

- ❑ Provider's Name (Ambulance Supplier's Company Name)
- ❑ National Provider Identifier (NPI)
- ❑ Provider's Number (PTAN)
- ❑ Provider's (Ambulance Supplier) Address
- ❑ Provider's (Ambulance Supplier) City, State & Zip
- ❑ State where Ambulance is Garaged
- ❑ Provider's (Ambulance Supplier) Fax Number

C: Beneficiary Information

- ❑ Beneficiary's First Name
- ❑ Beneficiary's Last Name
- ❑ Beneficiary's HIC Number (Medicare ID Number)
- ❑ Beneficiary's Date of Birth (mm/dd/yyyy)
- ❑ Beneficiary's Gender

D: Claim Information

- ❑ Start of 60 Day Period (mm/dd/yyyy)
- ❑ Procedure Code: **either A0428** *(BLS)* or **A0426** *(ALS)*
- ❑ Modifier 1 (Pick-up Location/1st leg of trip)
- ❑ Modifier 2 (Drop off Location/return leg)

D=Diagnostic/therapeutic site *E=Custodial facility (Assisted Living)* *G=Hospital based ESRD facility*
H=Hospital *J=Freestanding ESRD facility* *N=Skilled nursing facility*
R=Residence

- ❑ Certifying Physician's Name with Credentials (The certifying physician's name must match the physician's name listed on the PCS form **and** the physician signed medical documentation such as progress notes.)
- ❑ Certifying Physician's NPI (https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistrySearch.do?subAction=reset&searchType=ind)
- ❑ Certifying Physician's PTAN *(Optional)*
- ❑ Certifying Physician's Address
- ❑ Certifying Physician's City, State & Zip

E: Requestor Information

- ❑ Requestor's Name (The employee at the ambulance supplier who made the request for Prior Authorization)
- ❑ Requestor's Phone Number & Extension (This should be the direct line of the requestor at the ambulance supplier who can answer submission questions from CMS.
- ❑ Requestor's Signature
- ❑ Date Signed

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PRIOR AUTHORIZATION REJECTION PAR CODES

Code	Description
PAR 1	The documentation received did not contain the necessary PCS (Physician Certification Statement).
PAR 2	The documentation received did not indicate the origin and/or destination of the transports.
PAR 3	The PCS (Physician Certification Statement) received is missing a physician signature with credentials or is illegible.
PAR 4	The PCS (Physician Certification Statement) received is not dated or the date is pre-filled.
PAR 5	The Referring Physician name does not match the Certifying Physician on the Physician Certification Statement (PCS).
PAR 6	The PCS (Physician Certification Statement) received does not indicate why transportation by any other means is contraindicated.
PAR 7	The physician's signature on the PCS (Physician Certification Statement) was obtained after the requested "Start of the 60 Day Period" on the Prior Authorization request form. This signature must be obtained prior to the transport for scheduled, repetitive transports.
PAR 8	The physician's signature on the PCS (Physician Certification Statement) is greater than 60 days prior to the start of the 60 day period provided on the Prior Authorization Request form. The PCS is only valid for 60 days.
PAR 9	The "Request Type" section on the Prior Authorization Request form was incomplete. • Initial • Resubmission • Expedited (with reason) • Number of transports requested
PAR 10	The "Ambulance Supplier/Provider Information" section on the Prior Authorization Request form was incomplete. • Provider name • NPI • PTAN • Address • Address • State where ambulance is garaged
PAR 11	The "Beneficiary Information" section on the Prior Authorization Request form was incomplete. • First name • Last name • Health Insurance Number • Date of birth • Gender
PAR 12	The "Claim Information" section on the Prior Authorization Request form was incomplete. •Start of 60 day period • Procedure code • Modifier • Certifying physician's name • NPI • Address • City, State, Zip
PAR 13	The "Requestor Information" section on the Prior Authorization Request form was incomplete. • Name • Phone Number • Signature • Date
PAR 14	The documentation submitted does not support the transport services were medically necessary. The documentation supports that alternate services could have been used.
PAR 15	The documentation received does not support expedited requests.

http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Part-B~9QDMEF4013

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DATES TO REMEMBER

Palmetto GBA will begin accepting prior authorization requests.

December 15, 2015

January 1, 2016

Prior Authorization begins for states included in Phase 2.

Providers must have completed the PA process or the claim will be stopped for prepayment review.

After January 1, 2016

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COMMON PHASE ONE REJECTION REASONS

Supporting Medical Documentation Issues:

- Not submitting supporting medical documentation with the PCS form
- Submitting medical documentation that contradicted the PCS form
- Submitting medical documentation that wasn't current (greater than 60 days old from the requested start date)
- Submitting medical documentation that didn't include the patient's legible name
- Submitting medical documentation that wasn't signed by the certifying physician listed on the PCS form and/or the Prior Authorization form

Prior Authorization Form Issues:

- Incomplete supplier addresses listed
- Patient's name and HIC number don't match
- Patient's first and last names in wrong fields (flip flopped)
- Modifiers in the wrong fields or both modifiers in the same field
- Request type not marked
- Incorrect date of birth for the beneficiary listed
- Incorrect start date of the 60 day period listed
- Incorrect NPI of the certifying physician listed
- The certifying physician listed on the Prior Authorization form isn't the same physician who signed the medical documentation and/or the PCS form

PCS Form Issues:

- Not submitting a PCS form
- Submitting a PCS form that wasn't signed
- Submitting a PCS form that wasn't signed by the certifying physician listed on the Prior Authorization form and/or the medical documentation
- Submitting a PCS form with missing credentials
- Submitting an incomplete PCS form
- Submitting a PCS form more than 60 days prior to the first requested trip

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

Dear Physician/Practitioner:

The Medicare Fee-For-Service Program has implemented a three year **prior authorization program for repetitive scheduled non-emergent ambulance transports**. The goal of this program is to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments.

The prior authorization process for repetitive scheduled non-emergent ambulance transports began on December 1, 2014 in New Jersey, Pennsylvania, and South Carolina. On January 1, 2016, the program expands to Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished 3 or more times during a 10-day period; or at least once per week for at least 3 weeks. Medicare may cover repetitive, scheduled, non-emergent transportation by ambulance if

- Medical necessity requirements are met, and
- The ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that those medical necessity requirements were met.[1]

What You Need to Know

It is important to keep in mind that the prior authorization program does not create new documentation requirements for physicians/practitioners or suppliers – it simply requires the documentation to be submitted earlier in the claims process. **As the ordering physician/practitioner, you are required to supply the ambulance supplier or beneficiary the physician certification statement as well as any other documentation that supports medical necessity for the repetitive scheduled non-emergent ambulance transports.**

The non-emergent ambulance prior authorization program applies to the following Healthcare Common Procedure Coding System (HCPCS) codes:

- A0426 - Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1, and
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport.

[1] Per 42 C.F.R. § 410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished.

The ambulance supplier or beneficiary submits the prior authorization request with accompanying documentation to the appropriate Medicare Administrative Contractor (MAC).

The prior authorization request must include **all relevant documentation to support Medicare coverage of the transport.** This includes, but is not limited to:

- Documentation from the medical record to support the medical necessity of repetitive scheduled non-emergent ambulance transport
    - Documentation must show transportation by other means is contraindicated
    - Vague statements, such as "patient is bed-confined", are insufficient
    - Diagnosis of disease or illness may not be enough without corroborating evidence/statements
    - Attestation statements concerning the patient's requirements for ambulance transportation are not sufficient without corroborating evidence in the medical documentation
- Physician Certification Statement (PCS), including the certifying physician's name, National Provider Identifier and address
    - The PCS must be supported by the medical documentation
    - Bed-confinement or need for transportation cannot only be stated on the PCS
- Procedure codes
- Number of transports requested
    - The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips per prior authorization request in a 60-day period
- Information on the origin and destination of the transports
- Any other relevant document as deemed necessary by the MAC to process the prior authorization

For more information on coverage and documentation requirements, please refer to:

- MAC Jurisdiction M Palmetto Ambulance Information or
- MAC Jurisdiction L Novitas Local Coverage Determination (L35162).

Additional information about the program is available at http://go.cms.gov/PAAmbulance.

If your patient does not qualify for Medicare transportation services, there are state and local services that may be able to help. Beneficiaries, case managers and care givers may receive help locating other transportation services by contacting Eldercare at 1-800-677-1116 or their local State Health Insurance Assistance Program. Beneficiaries can also find additional information in the Ambulance Prior Authorization Introductory letter posted on the program website listed above.

If you have specific questions that are not addressed on this website please submit questions via e-mail to AmbulancePA@cms.hhs.gov.

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: _____ Destination: _____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

_____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

_____

2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/other ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

_____ _____

Signature of Physician* or Healthcare Professional Date Signed
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

www.pwwemslaw.com

Instructions for Sample Physician Certification Statement – Version 1.6

Terms of Use: this is a sample form only, designed to assist ambulance services in complying with applicable Medicare signature requirements. This form and the instructions are not legal advice and no attorney-client relationship is formed by their use. This is not an official form of any governmental agency and may not reflect requirements of state law where you live, or of other payors. Any individual or entity using this form ("user") or any modified version of it does so with the understanding that the user bears all responsibility for compliance with all applicable laws and regulations, and the user agrees that the designers of this form are not responsible for its use by any user. Do not use this form or any modification of it if you do not agree to the terms and conditions of this license. This form may be modified by the user to meet the user's needs, though we bear no responsibility for any modifications. This form is licensed only for use by individual ambulance services; and should not be forwarded to any other organization. Any other use or distribution requires our express written permission.

Who Should Use This Form: this form is a sample of a Physician Certification Statement (PCS). A PCS is a form that is required for most non-emergency ambulance transports of Medicare patients. This form is not required for emergencies.

Customizing This Form: users should delete the title "Sample Physician Certification Statement for Non-Emergency Ambulance Services – Version 1.5" and replace it with a title appropriate to their organization, such as "ABC Ambulance Physician Certification Statement" or may use a title such as "Physician Certification Statement for Non-Emergency Ambulance Services."

Completing This Form: this form should be filled out only by a person authorized by Medicare regulations to complete PCS forms for non-emergency ambulance services. For *scheduled, repetitive* patient transports (such as dialysis), the PCS may only be completed by the patient's attending physician. For unscheduled/non-repetitive transports, the PCS should be completed by the patient's attending physician whenever possible, but may also be completed by a Physician Assistant, Clinical Nurse Specialist, Registered Nurse, Nurse Practitioner, or Discharge Planner.

> Section I – General Information – this Section contains information such as patient name, transport date, and other general information.
>
> Section II – Medical Necessity Questionnaire – this Section should be completed only by the person authorized to sign the form under Medicare regulations. Please note that there is no specific format for medical necessity to be documented on a PCS form; this is merely one sample approach; users should use any approach that is suitable for them and that complies with the applicable Medicare regulations.

Section III – Signature of Physician or Healthcare Professional – this Section is where the patient's attending or other appropriate healthcare professional signs the form, and **prints their name and the date in which the form is signed**. In cases of scheduled, repetitive transports of Medicare patients, the form must be signed by the attending physician. For unscheduled/non-repetitive non-emergency transports, the form may be signed by one of the other individuals listed.

In Section III, this sample form also contains language that may be used by the person signing the form to sign on behalf of the patient authorizing the ambulance service to submit the claim under Medicare's applicable signature regulations. Those regulations permit "a representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services or assistance to the beneficiary" to sign on behalf of the patient to authorize submission of a claim to Medicare in cases where the patient is mentally or physically incapable of signing himself. However, because not every patient for whom a PCS form is completed will be "physically or mentally incapable of signing" themselves, the person signing the PCS should, if applicable check the box in Section III that states that the patient is incapable of signing his/her name, and then, if that is the case, should also write in a specific reason why the patient is unable to sign.