Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model

Operational Guide

UPDATED 01/10/2025

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1 - Purpose

The Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model is authorized by section 1834(l)(16) of the Social Security Act (the Act), as added by section 515(b) of Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10). It establishes a process through which a request for provisional affirmation of coverage is submitted for review before the service is furnished to a beneficiary and before the claim is submitted for payment. Prior authorization helps to make sure that applicable coverage, payment and coding rules are met before services are rendered.

The purpose of this Operational Guide is to interpret and clarify the prior authorization process for Medicare participating ambulance suppliers when rendering repetitive, scheduled non-emergent ambulance transports to Medicare Fee-for-Service beneficiaries. These guidelines aim to provide operational guidance and do not alter the requirements set forth in Title 42 of the Code of Federal Regulations (CFR) §410.40(e) and in applicable Local Coverage Determinations and Local Coverage Articles found at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

2 - Repetitive, Scheduled Non-Emergent Ambulance Transport Medicare Benefit

For any service to be covered by Medicare it must:

A. Be eligible for a defined Medicare benefit category,
B. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
C. Meet all other applicable Medicare statutory and regulatory requirements.

The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 CFR §410.40(e). Medicare covers ambulance services including air ambulance (fixed wing and rotary wing), when:

A. Furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.
B. 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.

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services can be found in 42 CFR §§410.40, 410.41, and in the publication 100-02 Medicare Benefit Policy Manual, Chapter 10.

Non-emergent transportation by ambulance is appropriate if either:

A. The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or,
B. The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.[1]

For a beneficiary to be considered bed-confined, the following criteria must be met: [2]

A. The beneficiary is unable to get up from bed without assistance.
B. The beneficiary is unable to ambulate.
C. The beneficiary is unable to sit in a chair or wheelchair.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in three or more round trips during a ten-day period; or at least one round trip per

[1] 42 CFR §410.40(e)(1).
[2] 42 CFR §410.40(e)(1).

week for at least three weeks.[3] Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment.

Medicare may cover repetitive, scheduled non-emergent transportation by ambulance if

A. The medical necessity requirements described above are met, and
B. The ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met (see 42 CFR §410.40(e)(1) and (2)).[4]

For more information on local coverage and documentation requirements, please refer to applicable Local Coverage Determinations and Articles found at the Medicare Coverage Database.

[3] Program Memorandum Intermediaries/Carriers, Transmittal AB-03-106.
[4] Per 42 CFR §410.40(e)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished.

3 - Model Overview

The model establishes a prior authorization process for repetitive, scheduled non-emergent ambulance transports to reduce the utilization of services that do not comply with Medicare policy while maintaining or improving quality of care. Prior authorization does not create any new documentation requirements. It requires the same information that is already required to support Medicare payment.

Prior authorization is voluntary; however, if the ambulance supplier elects to bypass prior authorization, applicable repetitive, scheduled non-emergent ambulance transport claims will be subject to a prepayment medical record review. Claims for the first three round trips (six one-way trips) are permitted to be billed without prior authorization and without being subject to prepayment medical record review.

3.1 - Model Inclusion

The model applies to independent ambulance suppliers that are not institutionally based providing Part B Medicare covered ambulance services billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction.

Ambulance suppliers under review by a Unified Program Integrity Contractor (UPIC) are **not** eligible to submit prior authorization requests.

Hospital-based ambulance providers owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program are **not** included and should **not** request prior authorization.

3.2 - Model Start Dates by State[5]

- New Jersey, Pennsylvania, and South Carolina started on December 1, 2014 for transports occurring on or after December 15, 2014.
- Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia started on December 15, 2015 for transports occurring on or after January 1, 2016.
- Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas (Jurisdiction H) started on November 17, 2021 for transports occurring on or after December 1, 2021.
- Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands, and Tennessee (Jurisdictions E and J) started on January 18, 2022 for transports occurring on or after February 1, 2022.
- Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands (Jurisdictions N, 5, and 6) started on March 18, 2022 for transports occurring on or after April 1, 2022.
- Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont (Jurisdictions K and 8) started on May 18, 2022 for transports occurring on or after June 1, 2022.

[5] Location is based on where the ambulance supplier is garaged.

- Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming (Jurisdictions F and 15) started on July 18, 2022 for transports occurring on or after August 1, 2022.
    - Railroad Retirement Board beneficiaries nationwide started on July 18, 2022 for transports occurring on or after August 1, 2022.

4 - Healthcare Common Procedure Coding System (HCPCS) Codes

The following ambulance HCPCS 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 is not needed for the mileage code, A0425, as it is treated as an associated procedure. Ambulance suppliers should bill the mileage code on the same claim as the transport code. Payments made for mileage are subject to recoupment if the transport code is denied.

Medicare Administrative Contractors (MACs) will not review prior authorization requests for transport codes that are not on this list.

5 - Number of Trips

A provisional affirmative prior authorization decision affirms a specified number of trips within a specific amount of time. The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips (which equates to 80 one-way trips) per prior authorization request in a 60-day period.

Alternatively, a provisional affirmative 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 less than a 60-day period. A provisional affirmative decision can be for all or part of the requested number of trips.

Transports exceeding 40 round trips (or 80 one-way trips) in a 60-day period require an additional prior authorization request.

The number of trips requested and authorized are measured in one-way trips.[6] As illustrated in the example chart below, if the beneficiary requires 40 round trips, the submitter should request 80 trips in the prior authorization request package.

	Number of Trips Needed During the 60-day period	**Number of Trips to Request in the Prior Authorization Package**
Example 1	20 round trips to wound care and back home	40 one-way trips
Example 2	40 round trips to dialysis and back home	80 one-way trips

5.1 - Special Consideration for Beneficiaries with a Chronic Medical Condition

The MAC may consider an extended affirmation period for beneficiaries with a chronic medical condition deemed not likely to improve over time. The medical records must clearly indicate that the medical condition is chronic, and the MAC must have established through two previous prior authorization requests that the beneficiary's medical condition has not changed or has deteriorated from previous requests before allowing an extended affirmation period.

- The decision to allow an extended affirmation period is at MAC discretion. The maximum number of requested trips remains at 40 round trips (80 one-way trips).
- The prior authorization decision for requests meeting the above criteria may affirm up to 120 round trips (which equates to 240 one-way trips) per prior authorization request in a 180-day period.
- Ambulance suppliers are still responsible for maintaining a valid Physician Certification Statement (PCS) at all times. The MAC reserve the right to request the PCS at any time.
- Each individual patient transport must still be reasonable and necessary, regardless of whether a new prior authorization is required.

[6] One round trip equals two one-way trips.

6 - Submitting a Request

The ambulance supplier or the beneficiary may submit the prior authorization request. Submitters are encouraged to use their respective MAC's form specifically designed for prior authorization requests. The form assists submitters with ensuring requests are complete.

Submitters should include the following data elements in a prior authorization request package:

Beneficiary Information
- Beneficiary name,
- Beneficiary Medicare number, and
- Beneficiary date of birth

Certifying Physician/Practitioner Information
- Physician/practitioner name,
- Physician/practitioner National Provider Identifier (NPI),
- Physician/practitioner Provider Transaction Access Number (PTAN) (optional), and
- Physician/practitioner address

Ambulance Supplier Information
- Ambulance supplier name,
- Ambulance supplier NPI,
- Ambulance supplier PTAN (optional), and
- Ambulance supplier address

Requestor Information
- Contact name and
- Telephone number

Other Information
- Number of one-way transports requested[7],
- HCPCS code,
- Submission date,
- Requested start date of the prior authorization period,
- Indicate if the request is an initial or resubmission review, and
- State where the ambulance is garaged

Additional Required Documentation
- Physician Certification Statement,
- Documentation from the medical record to support the medical necessity of the transports,
- Information on the origin and destination of the transports, and
- Any other relevant document as deemed necessary by the MAC to process the prior authorization request.

[7] One round trip equals two one-way trips.

6.1 - Submission Timeframes

Prior authorization should ideally be requested prior to rendering transports. Claims for the beneficiary's first three round trips (six one-way trips) are permitted to be billed without prior authorization to allow time to submit the prior authorization request and obtain approval. Prior authorization requirements start with the beneficiary's fourth round trip, even if the initial transports were rendered by a different ambulance supplier.

If additional time is needed to obtain approval beyond the first three round trips (six one-way trips), the ambulance supplier may continue to render the transports; however, claims should not be submitted for payment until the ambulance supplier has received notification of the prior authorization decision. If the prior authorization request is affirmed, it can retroactively apply to the previously rendered transports if the documentation supports the medical necessity at the time of transport.

6.2 - Submission Methods

Submitters may submit a prior authorization request to the appropriate MAC by either:

- Mail,
- Fax,
- Electronic submission of medical documentation (esMD), or
- MAC Provider Portal.

For esMD submissions, indicate document type "81" or "8.1". For more information about esMD, see www.cms.gov/esMD or contact your MAC.

6.3 - MAC Contact Information

MAC Jurisdiction, States, Website	**Telephone Number for Inquiries**	**Fax Number for Submissions**	**Mailing Address for Submissions**
JE – AS, CA, GU, HI, MP, NV	855-609-9960	701-433-3024	Noridian Healthcare Solutions Part B Prior Authorization PO Box XXXX Fargo, ND 58108-XXXX XXXX Corresponds to: • Northern California - 6774 • Southern California - 6775 • Nevada - 6776 • Hawaii and Pacific Islands – 6777
JF - AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	877-908-8431	701-433-3024	Noridian Healthcare Solutions Part B Prior Authorization PO Box XXXX Fargo, ND 58108-XXXX

MAC Jurisdiction, States, Website	Telephone Number for Inquiries	Fax Number for Submissions	Mailing Address for Submissions
			XXXX Corresponds to: • Alaska - 6703 • Arizona - 6704 • Idaho - 6701 • Montana - 6735 • North Dakota - 6706 • Oregon - 6702 • South Dakota - 6707 • Utah – 6725 • Washington - 6700 • Wyoming – 6708
JJ – AL, GA, TN	877-567-7271	803-462-7313	Palmetto GBA – JJ MAC Prior Auth P.O. Box 100212 Columbia, SC 29202-3212
JH - AR, CO, LA, MS, NM, OK, TX and JL – DC, DE, MD, NJ, PA	855-340-5975	833-200-9268	Novitas Solutions JL/JH Prior Authorization Requests (*specify jurisdiction*) PO Box 3702 Mechanicsburg, PA 17055 Priority Mailing Address Novitas Solutions Attention: JL/JH Prior Authorization Requests (*specify jurisdiction*) 2020 Technology Parkway Suite 100 Mechanicsburg, PA 17050
JK - CT, ME, MA, NH, NY, RI, VT	Provider Contact Center: 866-837-0241 NGSConnex: 866-837-0241	315-442-4178	National Government Services, Inc. Attn: Medical Review PAR PO Box 7108 Indianapolis, IN 46207-7108
JM – NC, SC, VA, WV	855-696-0705	803-462-2702	Palmetto GBA – JM MAC Prior Auth PO Box 100212 Columbia, SC, 29202-3212

MAC Jurisdiction, States, Website	Telephone Number for Inquiries	Fax Number for Submissions	Mailing Address for Submissions
JN - FL, PR, VI	855-340-5975	855-815-3065	First Coast Service Options, Inc. JN Prior Authorization P.O. Box 3033 Mechanicsburg, PA 17055 Priority Mailing Address First Coast Service Options, Inc. Attention: JN Prior Authorization 2020 Technology Parkway Suite 100 Mechanicsburg, PA 17050
J5 - IA, KS, MO, NE	866-518-3285	608-327-8514	WPS Government Health Administrators ATTN: Medical Review PO Box 7953 Madison, WI 53707-7953 Overnight or Certified Mail Delivery WPS Government Health Administrators ATTN: Medical Review 1717 W. Broadway Madison, WI 53713-1834
J6 - IL, MN, WI	Provider Contact Center: 866-234-7340 NGSConnex: 866-837-0241	717-565-3840	National Government Services, Inc. Attn: Medical Review PAR PO Box 7108 Indianapolis, IN 46207-7108
J8 - IN, MI	866-234-7331	608-327-8515	WPS Government Health Administrators ATTN: Medical Review PO Box 7954 Madison, WI 53707-7954 Overnight or Certified Mail Delivery WPS Government Health Administrators ATTN: Medical Review 1717 W. Broadway Madison, WI 53713-1834

MAC Jurisdiction, States, Website	Telephone Number for Inquiries	Fax Number for Submissions	Mailing Address for Submissions
J15 - KY, OH	866-276-9558	KY: 615-664-5934 OH: 615-664-5937	CGS PO Box 20203 Nashville, TN 37202
Railroad Medicare - Nationwide	888-355-9165	803-462-2632	RRB RSNAT P.O. Box 17089 Augusta, GA 30903-001

6.4 - Prior Authorization Request Review

After receipt of all relevant documentation, the MAC will make every effort to review and postmark the notification of their decision to the ambulance supplier[8] and the beneficiary within 7 calendar days for both initial and resubmitted requests.[9]

The option to request an expedited prior authorization review was removed on January 9, 2025. As prior authorization requests under this model are for non-emergent services that are scheduled in advance, they do not meet the criteria for an expedited review.

A prior authorization request can either be:

- Provisional affirmed (please see chapter **7 - Provisional Affirmative Decisions**),
- Non-affirmed (please see chapter **8 - Non-Affirmative Decisions**), or
- Rejected (please see chapter **10 – Rejected Prior Authorization Requests**).

See **Appendix A - Prior Authorization Request Process** for a visual representation of the prior authorization request process.

[8] If a third-party entity submits on behalf of the ambulance supplier, the notification of the decision will be sent to the ambulance supplier.

[9] Effective January 9, 2025, CMS changed the prior authorization review timeframe from 10 business days to 7 calendar days. This change aligns with the review timeframe in the CMS Interoperability and PA final rule (89 FR 8758) (Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving PA Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program).

7 - Provisional Affirmative Decisions

A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

After review, the MAC will send the decision letter with the provisional affirmative unique tracking number to the ambulance supplier via fax, mail, or the MAC provider portal (when available) postmarked within 7 calendar days. Decision letters sent via esMD are not available at this time. The MAC will also mail a copy of the decision letter to the beneficiary.

A provisional affirmative prior authorization decision does not follow the beneficiary. Only one ambulance supplier is allowed to request prior authorization per beneficiary per time period. If the initial supplier cannot complete the total number of prior authorized transports, the initial supplier should contact their MAC to cancel their prior authorization. A subsequent ambulance supplier may submit a prior authorization request to provide transport for the same beneficiary and must include the required documentation in the submission.

7.1 - Ambulance Supplier's Actions

Following receipt of an affirmative decision letter, the ambulance supplier should:

- Render the service to the beneficiary,
- Maintain all medical record documentation (i.e. PCS, clinical evaluations, nursing home records, trip sheets, etc.), and
- Submit the claim with the unique tracking number, as described in chapter **12 - Claim Submission with Prior Authorization**.

Generally, claims that have a provisional affirmative prior authorization decision will not be subject to additional review. However, CMS contractors, including Unified Program Integrity Contractors and MACs, may conduct targeted pre and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process. In addition, the Comprehensive Error Rate Testing contractor must review a random sample of claims for post-payment review for purposes of estimating the Medicare improper payment rate. If your claim is selected for review, the requesting contractor will provide guidance and directions in the Additional Documentation Request (ADR) letter.

See **Appendix A - Prior Authorization Request Process** for a visual representation of the prior authorization request process.

8 - Non-Affirmative Decisions

A non-affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service does not meet Medicare's coverage, coding, and payment requirements.

After review, the MAC will send the decision letter with the non-affirmative unique tracking number and details on why the prior authorization request was non-affirmed to the ambulance supplier via fax, mail, or the MAC provider portal (when available) postmarked within 7 calendar days. Decision letters sent via esMD are not available at this time. The MAC will also mail a copy of the decision letter to the beneficiary. Non-affirmative decisions are not appealable during the prior authorization process; however, resubmissions are unlimited.

Follow the tips below to avoid the top reasons for non-affirmative decisions:

- Include a PCS that:
  - Is complete,
  - Is signed by the patient's attending physician,
  - Includes credentials, and
  - Is dated less than 60 days before the requested start date.
- Include medical documentation that:
  - Supports what was on the PCS,
  - Supports the patient's condition at the requested time of transport,
  - Describes the medical necessity of the type and level of transport services by documenting the "what" and "why" of the patient's condition(s),
  - Includes the patient's name,
  - Is clear, and
  - Is from the patient's clinician and not the ambulance supplier.

8.1 - Ambulance Supplier's Action

Following receipt of a non-affirmative decision letter, the ambulance supplier has the following options:

- Resubmit another complete package with the additional documentation showing Medicare requirements have been met, as noted in the prior detailed decision letter(s). Resubmissions are unlimited during the prior authorization process. Please see chapter **9 - Resubmitting a Prior Authorization Request**.
- Render the service and submit the claim for payment with the non-affirmative unique tracking number, as described in chapter **12 - Claim Submission with Prior Authorization**. The MAC will deny the claim. All appeal rights are then available.
  - If applicable, also submit the claim to a secondary insurance, as described in chapter **11 - Secondary Insurance**.

See **Appendix A - Prior Authorization Request Process** for a visual representation of the prior authorization request process.

9 - Resubmitting a Prior Authorization Request

A resubmission is any subsequent submissions to correct an error or omission identified after the initial prior authorization request decision was non-affirmed and prior to claim submission.

When a prior authorization request is non-affirmed, the submitter should review the detailed decision letter. The submitter may then resubmit the request with all initial and additional documentation showing that Medicare requirements have been met using the same submission procedures. Resubmissions are unlimited during the prior authorization process, but each prior authorization request is reviewed individually.

Ambulance suppliers are encouraged to continue to provide medically necessary transports during the prior authorization resubmission process. However, claims should not be submitted for payment until the ambulance supplier has received notification of the prior authorization decision. If the prior authorization request is affirmed, it can retroactively apply to the previously rendered transports if the documentation supports the medical necessity at the time of transport.

The MAC will provide notification of the decision through a detailed decision letter postmarked within 7 calendar days to the ambulance supplier and the beneficiary.

See **Appendix A - Prior Authorization Request Process** for a visual representation of the prior authorization request process.

10 - Rejected Prior Authorization Requests

A prior authorization request is rejected when the MAC is unable to process the request due to incomplete or invalid information. The MAC will notify the submitter that their request was rejected and the reason why. Rejected prior authorization requests are not denials and are not reviewed for medical necessity.

When a prior authorization request is rejected, the submitter should review the reason listed in the rejection letter. The submitter may then correct the error and submit the request again using the same submission procedures. If the rejected request was an initial request, the submitter should also mark the next request as an initial request.

The following chart includes common rejection reasons and corrective actions:

Rejection Reason	**Additional Explanation**	**Ambulance Supplier's Corrective Action**
The request was submitted to the incorrect MAC	Location is based on where the ambulance supplier is garaged, except for Railroad Retirement beneficiaries.	Submit the request to the correct MAC responsible for processing requests for the state where the ambulance supplier is garaged. For Railroad Retirement beneficiaries, submit the request to Railroad Medicare (regardless of location).
The beneficiary has a Medicare Advantage Plan	This model applies to Medicare Fee-for-Service beneficiaries.	Contact the individual Medicare Advantage Plan for information on their prior authorization requirements.
The request contains an invalid/missing Medicare Beneficiary Identifier (MBI), beneficiary name, ambulance supplier NPI, HCPCS code, or start date.	Submitters must include certain data elements in a prior authorization request to be processed.	Submit a new request with the corrected information.
The ambulance supplier is under review by a UPIC.	Ambulance suppliers under review by a UPIC are **not** eligible to submit prior authorization requests.	Submit the ambulance claim as normal without a UTN.

The beneficiary already has an affirmed prior authorization on file with the same ambulance supplier.	Only one UTN is allowed per beneficiary per time period.	Adjust the dates on your prior authorization request so that the dates do no overlap and submit the request again.
The beneficiary already has an affirmed prior authorization on file with a different ambulance supplier. (The initial UTN is still in use.)	Only one ambulance supplier is allowed to request prior authorization per beneficiary per time period.	Adjust the dates on your prior authorization request so that the dates do no overlap and submit the request again, or submit the claim without prior authorization for prepayment medical record review.
The beneficiary already has an affirmed prior authorization on file from a different ambulance supplier. (The initial UTN is no longer in use.)	Only one ambulance supplier is allowed to request prior authorization per beneficiary per time period.	Verify with the beneficiary or their representative that they are no longer receiving transports from the initial ambulance supplier and the date the transports stopped. Attempt to coordinate with the initial ambulance supplier who should contact their MAC to approve the cancellation of the initial UTN. Contact your MAC with the above information if additional assistance is needed with the cancellation of the initial UTN.

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11 - Secondary Insurance

This chapter pertains to instances where the beneficiary has more than one insurance.

11.1 - Medicare is the Primary Insurance

In cases where Medicare is the primary insurance and another insurance company is secondary, ambulance suppliers or beneficiaries may submit the claim without a prior authorization decision if the claim is non-covered (GY modifier). A prior authorization is not needed and the claim will not develop due to the prior authorization model. Services billed as not medically necessary (GA modifier) will be developed and reviewed under the prior authorization model.

Ambulance suppliers or beneficiaries choosing to use prior authorization should do the following:

- Submit the prior authorization request with complete documentation as appropriate.
  - If the prior authorization request is non-affirmed:
    - Submit the claim with the non-affirmed unique tracking number to the MAC for payment, which will deny.
    - Forward the denied claim to the secondary insurance payee as appropriate to determine payment for the transport.

11.2 - Medicare is the Secondary Insurance

In cases where Medicare is the secondary insurance, ambulance suppliers and beneficiaries have the following two options:

1. Seek Prior Authorization:
   - The submitter submits the prior authorization request with complete documentation as appropriate. The request will be affirmed if all relevant Medicare coverage requirements **are** met for the transport.
   - The ambulance supplier renders the service and submits a claim to the other insurance company.
   - If the other insurance company denies the claim, the ambulance supplier or beneficiary can submit a claim to the MAC (listing the prior authorization tracking number on the claim). The MAC will pay the claim.

2. Skip Prior Authorization:
   - The ambulance supplier renders the service and submits a claim to the primary payer for a determination as appropriate.
   - If the other insurance company denies the claim, the ambulance supplier or beneficiary can submit a claim to the MAC. The MAC will stop the claim for prepayment medical record review and will send an ADR letter. The ambulance supplier should respond to the ADR.

12 - Claim Submission with Prior Authorization

12.1 - Affirmed Prior Authorization Decision

The submission of the prior authorized transport claim is to have the 14-byte unique tracking number that is located on the decision letter.

- For submission of a claim on a 1500 Claim Form, the unique tracking number is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.
- For submission of electronic claims, the unique tracking number is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.

12.2 - Non-Affirmed Prior Authorization Decision

The submission of the prior authorized transport claim is to have the 14-byte unique tracking number that is located on the decision letter.

- For submission of a claim on a 1500 Claim Form, the unique tracking number is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.
- For submission of electronic claims, the unique tracking number is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.

A claim submitted for payment with a non-affirmative prior authorization decision will deny. All appeal rights are then available. The claim could also be submitted to a secondary insurance, if applicable, as described in chapter **11 - Secondary Insurance**.

12.3 - Mileage Code Billing

The unique tracking number assigned to the transport code should not be included on the mileage code. Ambulance suppliers should bill the mileage code on the same claim as the transport code. Claims submitted with only the mileage code will be denied.

See **Appendix B - Claim Line Process with Prior Authorization** for a visual representation of the claim line process.

13 - Claim Submission without Prior Authorization

Prior authorization is voluntary; however, the MAC will stop an applicable claim for standard Medicare prepayment medical record review if submitted without a prior authorization request decision.[10]

Ambulance suppliers do not need to do anything differently when submitting a claim without a unique tracking number. They do not need to put any information in the remarks field or submit any unsolicited documentation at the time of claim submission.

Since a claim alone does not identify if a transport is scheduled in advance, it is possible for repetitive, unscheduled non-emergent ambulance transport claims to trigger a prepayment medical record review. If this occurs, the ambulance supplier should follow the prepayment medical record review process described below in order to receive payment for medically necessary transports.

13.1 - The Prepayment Medical Record Review Process

Prepayment medical record review means that the MAC will make a claim determination before claim payment using the standard Medicare prepayment medical record review process:[11]

- The MAC will stop the claim prior to payment and send the ambulance supplier an ADR letter through the US Postal Service and/or electronically.
- The ambulance supplier will have 45 days to respond to the ADR with all requested documentation via:
  - Fax,
  - Mail, or
  - esMD (for more information see: www.cms.gov/esMD).
- The MAC will have 30 days to review the documentation and render a claim determination.

See **Appendix C - Claim Line Process without Prior Authorization** for a visual representation of the claim line process.

[10] Claims for the beneficiary's first three round trips (six one-way trips) are permitted to be billed without prior authorization and without being subject to prepayment medical record review. Prior authorization requirements start with the beneficiary's fourth round trip, even if the initial transports were rendered by a different ambulance supplier.

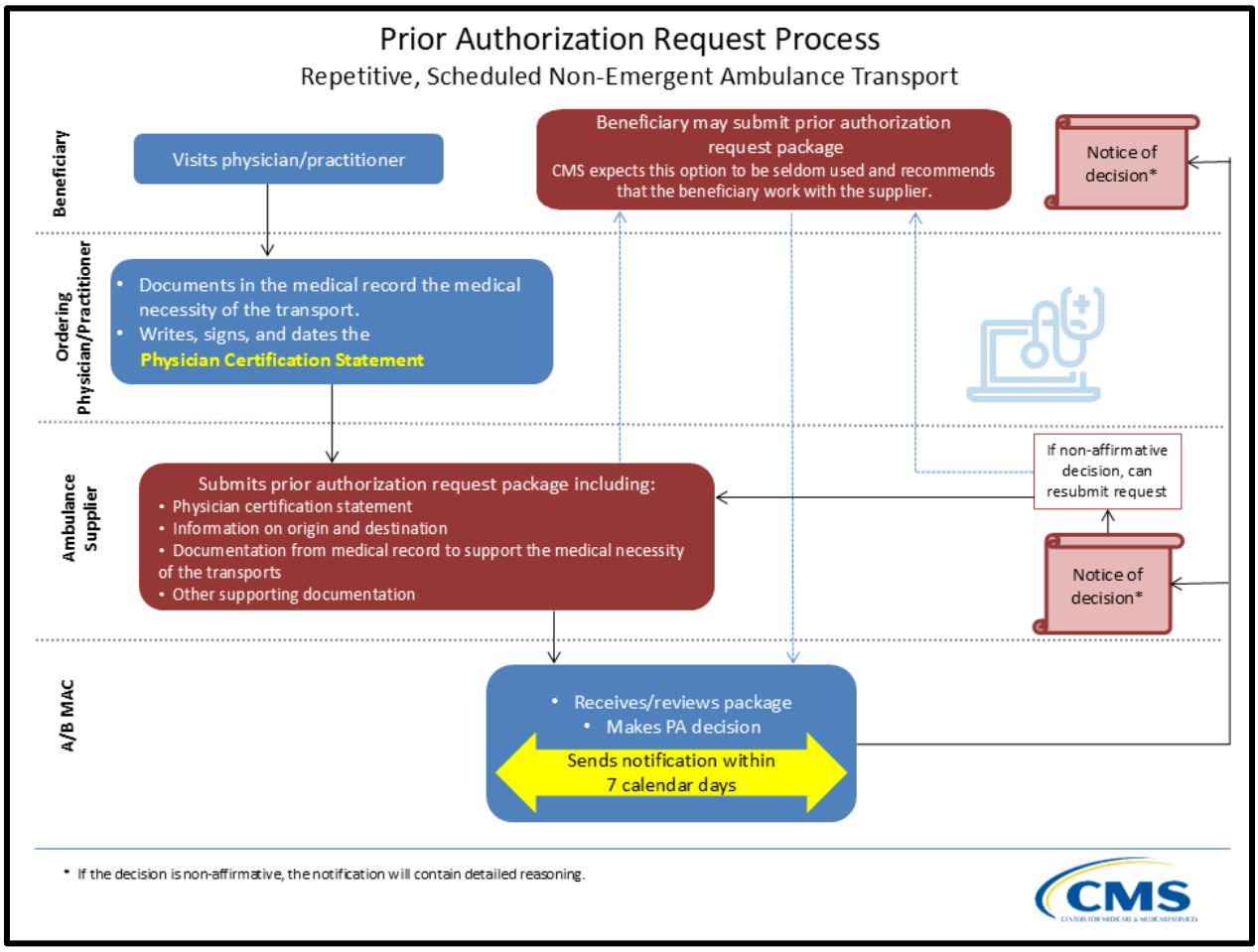
[11] For additional information on the standard Medicare prepayment medical record review process, please see the CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 3, §3.2.

14 - Claim Appeals

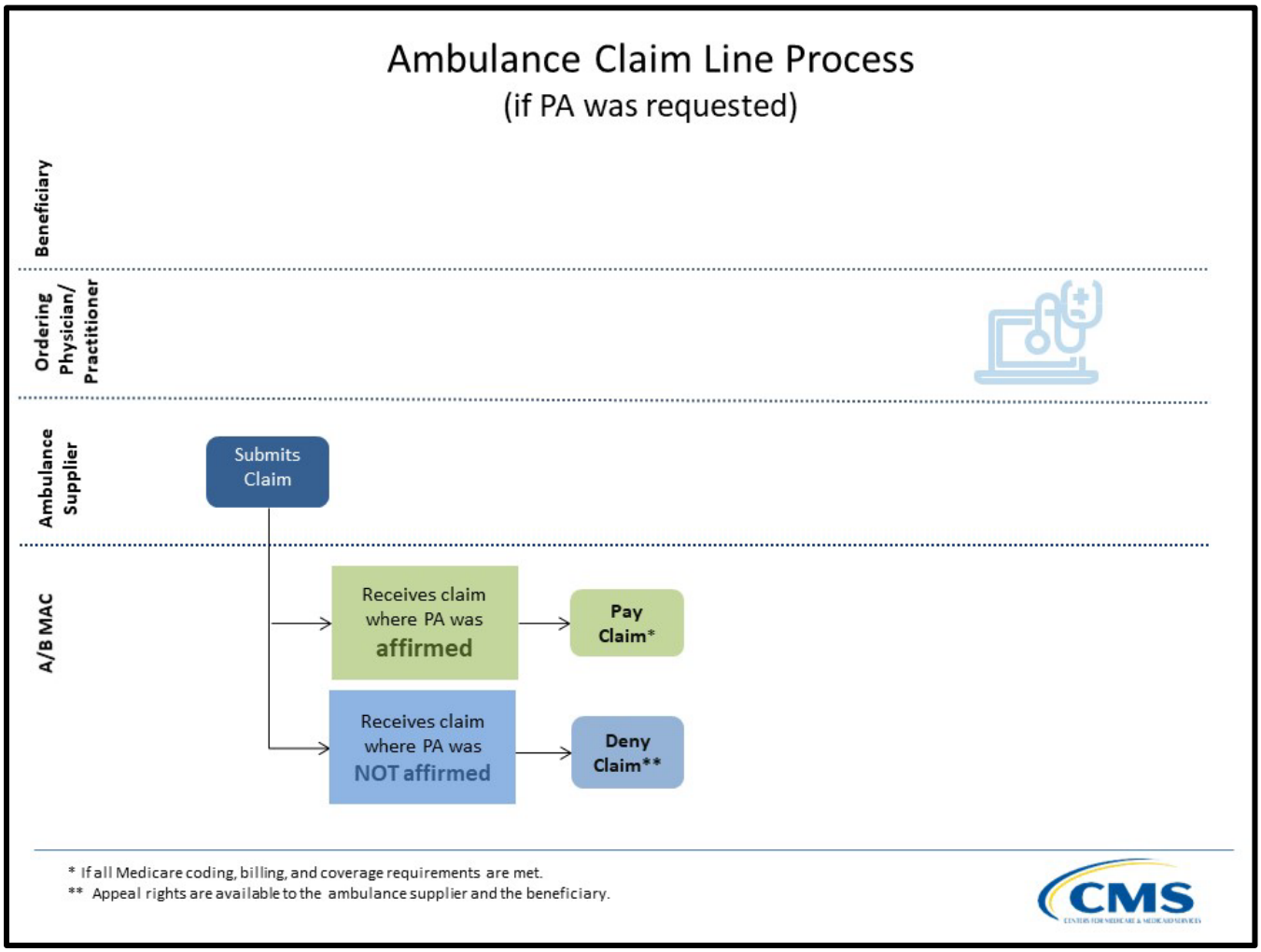
Appeals follow all current procedures. For further information, consult the Medicare Claims Processing Manual publication 100-04, chapter 29 Appeals of Claims Decision.

The prior authorization model does not include a separate appeal process for a non-affirmative prior authorization decision. However, a non-affirmative prior authorization decision does not prevent the ambulance supplier from submitting a claim. Such a submission of a claim and resulting denial by the MAC would constitute an initial determination that would make the appeals process available for disputes by beneficiaries and ambulance suppliers.

Appendix A - Prior Authorization Request Process



Appendix B - Claim Line Process with Prior Authorization



Appendix C - Claim Line Process without Prior Authorization