Open discussion period ends 08/31/2022

Medicare file code CMS-4203-NC open discussion comment:

As it pertains to ambulance coverage, some of the challenges with the MA plans vs. traditional are the requirements for prior authorization, a lack of clear coverage categories when determining eligibility, appeal rights for the provider, utilization of outside brokers, coverage co-payments for individual ambulance transports.

Traditional Medicare does not require a prior authorization for a non-emergency ambulance transport unless it is for routine pre-scheduled repetitive transports for appointments such as dialysis, radiation, and wound care. Many Medicare Advantage Plans are requiring a prior authorization in order to bill for a non-emergency transport. Ambulance transportation has medical necessity and reasonableness guidelines that are already established by CMS by regulations that have been defined and are very well known to anyone in the industry that has enrolled as a Part B Medicare Provider.

When the Medicare Advantage Plans are permitted to set separate guidelines, this creates challenges that are layers deep to any provider. There are multiple sets of guidelines then created to demand a prior authorization, which to obtain is an administrative burden that creates an additional payroll expense on any party that is involved with receiving one. Typically, you will either be on the phone for over 30 minutes to request this, or you go online to complete a request, or send a fax that will not be answered timely prior to transport. Unless the requirement to obtain the authorization is on the ordering facility it is not reasonable to require this from the ambulance provider. The ambulance provider only knows what is relayed to them over the phone, they have not had patient contact at this point. Yet, the ambulance providers are left with a transport that is not billable after they have provided a service. An example of this lengthy process would be Anthem Senior wait time on calls are typically longer than 30 minutes.

When requesting coverage eligibility, non-emergency ambulance transportation is not something that you will find in the data returned. With Traditional Medicare you know what is covered and when it is not, and you know the deductible amount for each member annually. There is not a surprise in the long run to find out that the beneficiaries coverage required an authorization or a specific provider to provide their transport or that they have a $250.00 co-payment for every transport vs an annual $233.00. When the beneficiary is also a recipient of Medicaid, in most cases they will not cover the co-payment because it is more than what they would allow. This puts the provider in a place that they will not be able to collect the allowable amount from anyone. Humana is a prime example of individual trip co-payments.

When the MA plans deny a claim, to appeal it, the MA requires the providers to submit a waiver that relieves them of the right to bill the beneficiary in the event the appeal is upheld. In many cases the denial is a result of multiple transports on the same day, they may not even be with the same provider. Is it reasonable to expect the provider to sign a waiver prohibiting them to seek payment from the beneficiary in that scenario?

Some MA Plans have a pre-determined list of ICD-10 codes that they require to approve the claim. The list may say it is not all inclusive, but they will deny the claim if you use something different. In this situation, the edits are not always published to allow the provider the ability to submit a clean claim. This creates the additional burden on the provider to continuously resubmit claims and appeal claims in hopes of payment. And example of the preapproved list of ICD-10 codes that are still consistently denied would be with Wellcare.

When outside brokers are appointed to manage the transportation, they are requiring the providers to credential with them independently and have stipulations that are well beyond the requirements of Traditional Medicare or Medicaid. Brokers such as National Med Trans, Modivcare, MTM all require transportation to be coordinated through them, and will only use ambulance providers within their network and some will not even accept the provider if they are unbale to commit to long distance psychiatric transfers or bariatric transportation. With Traditional Medicare, the provider knows the fee schedule, brokers will try and make the provider sign an agreement at rates much lower than the Medicare Fee schedule.

With the goal to move beneficiaries to a Medicare Advantage Plan, this can pose a great risk to the ambulance industry without additional guidance and requirements from CMS. If a provider is already credentialed through Medicare and Medicaid, they should not require separate credentialing with the MA or a Broker. Deductibles or Co-Payments need to be reasonable and inline with Medicare Part B. Prior authorization should not be required without reasonable appeal expectations that allow for the provider to submit a claim based on the patient’s condition when it meets Medicare’s definition of Medically Necessary. These requirements can have a huge impact on a provider financially and they need the backing of CMS to prevent abuse of the MA Plan at their expense.

Thank you for listening to our concerns.

Respectfully,