DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	June 1, 2016	Initial version of Uniform Managed Care Manual Chapter 15.5, "Non-Emergency Ambulance Services Request Instructions" Chapter 15.5 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.

[1] Status is represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

[2] Revisions are numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

Use of Texas Standard Prior Authorization Request Form for Health Care Services for Non-Emergency Ambulance Services

APPLICABILITY OF CHAPTER 15.5

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, STAR Health, and STAR Kids Programs. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration), STAR Health, and STAR Kids Programs. The term "MCO" may include health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance (TDI). The requirements in this chapter apply to all programs, except where noted.

PURPOSE AND BACKGROUND

Effective September 1, 2015, MCOs are required to accept the Texas Standard Prior Authorization Request Form for Health Care Services developed by the Texas Department of Insurance. A copy of the form can be found here: http://www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf . The instructions in this chapter are to be used if submitting the form for non-emergency ambulance services. Medicaid providers may choose to use the Texas Standards Prior Authorization form or any other form accepted by the Medicaid MCO.

Terminology

One-time, non-repeating: One-time, nonrepeating requests are reserved for those clients who require a one-time transport. Supporting documentation should include an order signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition.

Recurring: Recurring requests, up to 60 days, are reserved for those clients whose transportation needs are not anticipated to last longer than 60 days. Supporting documentation should include an order signed and dated by a physician, PA, NP, or CNS. The request must include the approximate number of visits needed for the repetitive transport (e.g., dialysis, radiation therapy).

Section I – Submission

In accordance with Human Resources Code (HRC) §32.024 (t), the prior authorization form must be submitted by a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party before an ambulance is used to transport a client in circumstances not involving an emergency. Other responsible parties include staff working with a health care service provider submitting prior authorizations on behalf of the provider or facility. An ambulance provider may not submit a prior authorization for non-emergent ambulance transports.

Issuer Name: Include the Managed Care Organization (MCO) name

Phone: Insert the MCO phone number

Fax: Insert MCO fax number

Date: Insert date authorization request form is completed by provider

Section II – General Information

Review Type:

- Non-urgent request should be checked for any recipient that requires a scheduled transport in excess of 24 hours from the date of the request. This typically applies for transportation to medical appointments, or other ongoing treatment such as dialysis or hyperbaric treatment.
- Urgent request should be checked for any recipient that requires a scheduled transport on the date the authorization request form is completed.
- Clinical Reason for Urgency: Include why the prior authorization is needed within 24 hours.

Request Type:

- Check “Initial Request” if the authorization form represents an initial ambulance transport request.
- Check “Extension/Renewal/Amendment” if the authorization represents a continuation of a prior authorization for patients requiring recurring transports.

Prev. Auth. #: For patients who have been approved for recurring transports , include the prior authorization number related to the non-emergency ambulance transports for those treatments; otherwise, leave blank.

Section III – Patient Information

Name: Insert patient’s name as listed on their member identification card.

Subscriber Name (if different): Leave blank

Phone: Insert patient’s phone number or guarantor’s phone number if patient is a minor

Member or Medicaid ID#: Insert patient's Medicaid identification number

DOB: Insert patient's date of birth.

Gender: Insert patient's gender.

Group #: Leave blank

Section IV – Provider Information

Requesting Provider or Facility

Name: Insert name of provider/facility

NPI#: Insert National Provider Identification Number of provider/facility

Specialty: Include "Hospital" or "Family Physician" or "Skilled Nursing Facility" or the applicable specialty of the requesting provider/facility

Phone: Insert Provider/Facility phone number

Fax: Insert Provider/Facility fax number

Contact Name: Insert the name of the person submitting the prior authorization form; this may include administrative staff at a health care facility. Please note that administrative staff will still be required to submit orders with the prior authorization.

Phone: Insert the phone number of the person listed as the "Contact Name"

Requesting Provider's Signature and Date (if required): Insert the signature of the individual listed as the contact for the prior authorization form.

Service Provider or Facility

Name: Insert the name of the ambulance service agency to provide the ambulance transportation.

NPI#: Insert ambulance NPI number

Specialty: Insert "Ambulance Transport"

Phone: Insert the phone number for the ambulance provider

Fax: Insert the fax number for the ambulance provider

Primary Care Provider Name (see instructions): Leave blank

Phone: Leave blank

Fax: Leave blank

Note: Include the addresses for the servicing and requesting providers in Section VI.

Section V – Services Requested

Planned Service or Procedure: Include the level of ambulance transportation requested:

- Basic Life Support (HCPCS Code A0428),
- Advanced Life Support (HCPCS Code A0426) or
- Specialty Care Transport (HCPCS Code A0434). Include the requested destination facility for this patient or indicate “residence”.

Code: Insert the code that corresponds to the description under “Planned Service or Procedure”

- “A0428” for Basic Life Support,
- “A0426” for Advanced Life Support,
- “A0434” for Specialty Care Transport.

In addition to one of the previous codes, “A0425” for mileage should be on every prior authorization request. In the event oxygen is required enroute, “A0422” should be inserted.

Start Date: Insert the beginning date of the authorization for requested ambulance service.

End Date: Insert the ending date of the authorization for requested ambulance service. For authorizations for patients who require multiple transports due to dialysis treatment, hyperbaric treatment, or similar services this date should not exceed 60 days as defined in TAC 354.1115.

Diagnosis Description: Include the patient’s primary diagnosis that indicates medical necessity for ground ambulance transportation.

Code: Insert the diagnosis code that corresponds with the diagnosis description above.

Check Boxes that begin with “Inpatient”: Check “Other” and insert “ambulance”

Check Boxes that begin with “Physical Therapy”: Leave blank

Check Boxes that begin with “Home Health”: Leave blank

Check Boxes that begin with DME: Leave blank

Section VI – Clinical Documentation

Clinical documentation should at minimum include the elements below.

1. **Physician’s orders:** Include the following information from the physician or physician extender’s orders, as well as a copy for non-emergency ambulance transportation including, but not limited to:
    a. Date of request
    b. Name of physician or physician extender

   c. Credentials
2. **Address**: Include the origin and destination addresses.
3. **Reasons for transport:** Include all pertinent information regarding why the patient must be transported by ground ambulance. The documentation submitted must include specific clinical information regarding the condition of the patient that necessitates this type of transportation.
4. **Supporting Documentation:** Include any supporting documentation such as physician or nursing progress notes, Medication Administration Records or other relevant documentation to support mode of transport, if applicable.
5. **Number of transports:** If request is for a recurring transport specify the number of transports requested.
6. **Requesting Provider Address:** Include the address for the requesting provider in order to identify the office/branch of a larger company.
7. **Servicing Provider Address:** Include the address for the servicing provider in order to identify the office/branch of a larger company.