Draft Operational Guidance For Using the TDI Standard Prior Authorization Form For Non-Emergency Ambulance Transports Comments Due By September 4, 2015

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, see Attachment "2. nofr001". HHSC has developed draft instructions to be used if submitting the form for non-emergency ambulance transportation services, see attachment labeled "3. Draft Non-Emergency Ambulance Instructions".

REQUEST
HHSC requests MCOs to review the draft instructions and submit written comments to via email to Daniela De Luna Olivares, Program Advisor at daniela.deluna@hhsc.state.tx.us by close of business on **September 4, 2015**.

Attachment 2

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions: Section I – Submission:

An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:

Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
  - If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*

Note: *If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal,*

Attachment 3

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. Stamped or computerized signatures and dates are not accepted. The request must include the approximate number of visits needed for the repetitive transport (e.g., dialysis, radiation therapy).

Section I – Submission

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

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.