

Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model Frequently Asked Questions

1. Is the RSNAT Prior Authorization Model expanding nationwide?

The Centers for Medicare & Medicaid Services (CMS) [announced](#) on September 22, 2020 that it will expand the model nationwide, as the model has met all expansion criteria.

2. When are the effective dates of the RSNAT Prior Authorization Model?

The model began in South Carolina, New Jersey, and Pennsylvania on December 1, 2014, for transports occurring on or after December 15, 2014.

The model began in Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia on December 15, 2015, for transports occurring on or after January 1, 2016.

CMS is continuing to monitor the public health emergency and will release more information on implementation dates for the remaining states and territories as it becomes available.

Location is based on where the ambulance supplier is garaged.

3. Under what authority is CMS operating the model?

CMS is expanding the RSNAT Prior Authorization Model nationwide as required under section 1834(1)(16) of the Act, as added by section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10).

The model originally began as a CMS Center for Medicare and Medicaid Innovation Center model under section 1115A of the Social Security Act (the Act) that tested whether prior authorization helped to reduce expenditures, while maintaining or improving quality of care. This model operated in Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia.

4. When will the model end?

The expanded model does not have a specified end date.

The original model that operated in Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia ended under section 1115A of the Act on December 1, 2020. These states transitioned without interruption to the expanded model under MACRA on December 2, 2020.

5. What were the criteria for nationwide expansion?

Section 515(b) of MACRA (Pub. L. 114-10) requires CMS to expand the model to all states if the requirements described in paragraphs (1) through (3) of section 1115A(c) of the Act are met:

- 1) The Secretary determines that such expansion is expected to—
 - (A) Reduce spending under applicable title without reducing the quality of care; or
 - (B) Improve the quality of patient care without increasing spending;
- (2) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and
- (3) The Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

6. What were the evaluation findings of the original model that operated under section 1115A of the Act?

To date, CMS has released two interim evaluation reports conducted by CMS contractor, Mathematica Policy Research. Most recently, the Second Interim Evaluation Report¹ found that the model was successful in reducing repetitive, scheduled non-emergent ambulance transport spending and total Medicare spending while maintaining overall quality of and access to care. These findings were similar to the First Interim Evaluation Report.² In comparison to groups of similar states, the model has reduced both repetitive, scheduled non-emergent ambulance transport use and expenditures, by 63 percent and 72 percent, respectively, in the model states, resulting in a reduction of approximately \$550 million in expenditures over 4 years for the population examined: beneficiaries with end-stage renal disease, severe pressure ulcers, or both. The evaluation reports found that the prior authorization model overall had no impact on quality measures or adverse events.

7. What were the Chief Actuary’s findings on model expansion?

The Chief Actuary of CMS certified³ that expansion of the model would reduce program spending under the Medicare program, thereby satisfying the requirements of section 1115A(c)(2) of the Act, stating that even under the most conservative assumptions, the projected savings from expansion would significantly outweigh the cost of administering the prior authorization policy.

8. What was the Secretary’s determination on model expansion?

Based on the Chief Actuary certification and the Interim Evaluation Reports, the Secretary of the Department of Health and Human Services determined that the model met the statutory criteria for expansion under sections 1115A(c)(1) and (c)(3) of the Act. CMS is therefore required under section 1834(l)(16) of the Act, as added by section 515(b) of MACRA (Pub. L. 114-10), to expand the model nationwide.

¹ <https://innovation.cms.gov/data-and-reports/2020/rsnat-secondintevalrpt>

² <https://innovation.cms.gov/files/reports/rsnat-firstintevalrpt.pdf>

³ <https://www.cms.gov/files/document/certification-medicare-prior-authorization-model-repetitive-scheduled-non-emergent-ambulance.pdf>

9. Did the model receive approval under the Paperwork Reduction Act (PRA) of 1995?

CMS received approval for an expanded model from the Office of Management and Budget (OMB). The OMB approval control number is 0938-1380.

The original model was exempt from PRA, as Section 1115A(d)(3) of the Act states that PRA does not apply to the testing of models under section 1115A of the Act.

10. How did CMS choose the states for the original model?

CMS chose New Jersey, Pennsylvania, and South Carolina for initial implementation of the prior authorization model because of their high utilization and improper payment rates for these services. The June 2013 Medicare Payment Advisory Commission's (MedPAC) Report to Congress: "Medicare and the Health Care Delivery System" found that six states had higher than average spending on non-emergent ambulance transport per dialysis beneficiary than other states. When these six states were ranked by total Medicare expenditures on non-emergent ambulance services, New Jersey, Pennsylvania, and South Carolina were in the top three.

CMS added Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia in accordance with section 515(a) of MACRA.

11. Why did CMS originally choose to test a prior authorization model on repetitive, scheduled non-emergent ambulance transport?

According to the Government Accountability Office "Cost and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased," the number of Basic Life Support non-emergent transports for Medicare Fee-For-Service beneficiaries increased by 59 percent from 2004 to 2010.

The Department of Health and Human Services Office of Inspector General (OIG) has published numerous reports about Medicare's ambulance benefit and has concluded that this benefit is highly vulnerable to abuse. A 2006 OIG study, "Medicare Payment for Ambulance Transport" evaluated the appropriate use of the ambulance benefit and the findings indicated a 20 percent nationwide improper payment rate for non-emergent ambulance transport, meaning 20 percent of non-emergent transports did not meet Medicare's coverage requirements. The report recommended that CMS implement activities to reduce these improper payments.

In addition, in June 2013, MedPAC published a report that included an analysis of non-emergent ambulance transports to dialysis facilities. Transports to and from dialysis facilities have grown noticeably in recent years and represent a large share of non-emergent ambulance claims. In the 5-year period between 2007 and 2011, the volume of transports to and from a dialysis facility increased 20 percent, more than twice the rate of all other ambulance transports combined. In 2011, ambulance transports to and from dialysis facilities accounted for nearly \$700 million in Medicare spending, or approximately 13 percent of Medicare expenditures on ambulance services.

12. How does the expanded model differ from the original model?

The expanded model follows a similar design as the original model that operated under section 1115A of the Act. Based on stakeholder feedback, CMS decreased the review timeframe for resubmitted requests from 20 business days to 10 business days.

Prior Authorization

13. What is prior authorization?

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before the service is rendered to a beneficiary and before a claim is submitted for payment. Prior authorization helps to make sure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. Some insurance companies, such as TRICARE, certain Medicaid programs, and the private sector, use prior authorization processes to help ensure proper payment before the service is rendered.

14. What does the prior authorization model do?

The model establishes a prior authorization process for repetitive, scheduled non-emergent ambulance transports to Medicare Fee-for-Service beneficiaries rendered by independent ambulance suppliers participating in Medicare. The model helps reduce medically unnecessary expenditures, reduce improper payments, and protect the Medicare Trust Funds while maintaining or improving access to and quality of care.

15. Are hospital-based ambulance providers included in the model?

No, 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 in this model and should not request prior authorization.

16. Are independent ambulance suppliers included in the model?

Yes, independent ambulance suppliers are included in this model.

17. Is prior authorization necessary for beneficiaries during a covered Medicare Part A stay?

If the ambulance transport is included in the bundled Part A payment and is not billed separately to Medicare by the ambulance supplier, prior authorization is not necessary.

18. Are transports of beneficiaries in a skilled nursing facility (SNF) subject to prior authorization?

Transports of beneficiaries in a SNF are subject to prior authorization if the ambulance transport is not included in the bundled SNF payment and an independent ambulance supplier is providing the transport.

19. Are facilities responsible for submitting prior authorization requests?

No, the ambulance supplier or beneficiary is responsible for submitting the prior authorization requests.

20. Are ambulance suppliers under review by a Unified Program Integrity Contractor (UPIC) subject to prior authorization?

No, ambulance suppliers under review by a UPIC are not eligible to submit prior authorization requests.

21. What does the ambulance Medicare benefit cover?

Medicare covers ambulance services only when medically necessary, which means using other types of transportation could endanger a person's health. To satisfy the medical necessity requirement, the person's condition must require both the ambulance transport and the level of service provided. In addition, the reason for the transport must be to get a Medicare-covered service or return from a covered service. If all requirements aren't met, the person may be billed for ambulance services even if there isn't a signed Advance Beneficiary Notice of Non-Coverage (ABN). Whether or not a person has a physician's order for an ambulance transport doesn't necessarily prove that the transport was medically necessary. For Medicare to pay for the services, the ambulance must meet all Medicare coverage criteria at 42 C.F.R. §§ 410.40, 410.41; Pub. 100-02, *Medicare Benefit Policy Manual*, Ch. 10, §10.2.1.

22. What is the definition of repetitive ambulance transport?

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

23. Does prior authorization create new documentation requirements?

Prior authorization does not create new documentation requirements. Instead, it requires the same information that is already required to support Medicare payment, just earlier in the process.

24. Is prior authorization required for repetitive, scheduled non-emergent ambulance transports?

Prior authorization for repetitive, scheduled non-emergent ambulance transports is voluntary; however, if the ambulance supplier elects not to submit a prior authorization request before the fourth round trip in a 30-day period, the claim related to the repetitive, scheduled non-emergent ambulance transport will be subject to a prepayment medical review.

Prior Authorization Requests

25. What is a prior authorization request?

A prior authorization request is a request for provisional affirmation of coverage through medical review of the medical documentation that supports the medical necessity of the repetitive, scheduled non-emergent ambulance transports. Ambulance suppliers are encouraged to submit the prior authorization request prior to the beneficiary's fourth trip in a 30-day period.

26. What is a prior authorization decision?

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

27. How does CMS administer the prior authorization process? Is there specialized staff devoted to the program?

The Medicare Administrative Contractors (MACs) administer the prior authorization process. These contractors currently process claims and conduct medical review for part B services. Clinical staff are assigned to medical review and trained to provide consistency in prior authorization decisions. In addition, we employ private sector standards in our prior authorization program, such as responding to prior authorization requests within ten days of receipt of a prior authorization package, providing responses that are specific about missing information, and giving ambulance suppliers the opportunity to resubmit the prior authorization package for re-review with additional information.

28. How long does Medicare have to provisionally affirm or non-affirm a prior authorization request?

Medicare, through the MACs, will make every effort to postmark a decision on a prior authorization request within ten business days for both initial and resubmitted requests.

29. What is a resubmitted request?

A resubmitted request is a prior authorization request resubmitted with additional documentation after the initial prior authorization request was non-affirmed. Unlimited resubmissions are allowed.

30. Can prior authorization requests be submitted electronically?

Yes. Submitters who choose to utilize the prior authorization process may send prior authorization requests to the MACs via mail, fax, MAC provider portals, or through the Electronic Submission of Medical Documentation (esMD) system. More information can be found at <http://www.cms.gov/esMD>.

31. In what cases could a submitter request an expedited review?

A submitter may request an expedited review when the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. MACs will make reasonable efforts to communicate a decision within two business days of receipt of all applicable Medicare required documentation. As this model is for non-emergent services, CMS expects requests for expedited reviews to be extremely rare.

Submitters should indicate the need for an expedited review on the prior authorization request package.

32. Is there a tracking number for each prior authorization decision?

Yes, MACs will list the prior authorization unique tracking number on the decision letter. Ambulance suppliers must submit this unique tracking number on the claim.

33. Where on the claim should the unique tracking number be populated?

When submitting an electronic 837 professional claim for a prior authorized service, the unique tracking number (UTN) must be submitted in the 2300 Claim Information loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).

When submitting a paper CMS 1500 Claim form for a prior authorized service, the UTN must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.

34. How long can the unique tracking number be used?

A unique tracking number is only valid for the affirmed number of trips during the affirmed time period indicated on the decision letter. Claims submitted with an invalid tracking number will be denied. If additional trips are needed, a new prior authorization request may be submitted to obtain a new unique tracking number.

35. Will these claims still be subject to additional post-payment reviews?

Generally, the claims that have a provisional affirmative prior authorization decision will not be subject to additional review. However, CMS contractors, including UPICs and MACs, may conduct targeted pre- and post-payment reviews to ensure that claims include 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.

36. Is a new prior authorization required if the beneficiary's level of service changes from BLS to ALS?

Yes, a new prior authorization would need to be submitted.

37. How many trips are allowed without prior authorization before the prepayment review begins?

If a prior authorization has not been requested before the fourth round trip in a 30-day period, claims will be subject to prepayment medical review. CMS monitors utilization patterns to ensure that suppliers of ambulance services are not routinely limiting needed services to a certain number of trips in order to avoid the prior authorization process.

38. How many ambulance suppliers can request prior authorization for one beneficiary for one time period?

Under this model, CMS allows one ambulance supplier to request prior authorization per beneficiary per time period. If the initial supplier cannot complete the total number of prior authorized transports (e.g., initial ambulance company closes or no longer services that area), the initial supplier's request is cancelled. In this situation, 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.

If multiple ambulance suppliers are providing transports to the beneficiary during the same or overlapping time period, the prior authorization request will only cover the supplier for whom the request was made. Any claims submitted for which no prior authorization request is recorded will be subject to prepayment review if prior authorization has not been requested by the fourth round trip in a 30-day period.

39. How many trips are allowed under a single prior authorization request?

A provisional affirmative prior authorization decision affirms a specified number of trips within a specific amount of time and can be for all or part of the requested number of trips. 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. Transports exceeding 40 round trips (or 80 one-way trips) in a 60-day period require an additional prior authorization request.

The MAC may consider an extended affirmation period for beneficiaries with a chronic medical condition that is deemed not likely to improve over time. The prior authorization decision, justified by the beneficiary's chronic medical condition, 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.

40. How do I request an extended affirmation period for a beneficiary with a chronic medical condition?

The decision to allow an extended affirmation period is at MAC discretion. The maximum number of trips that can be requested remains at 40 round trips (80 one-way trips). 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.

41. Should a physician attestation of medical necessity be included in the prior authorization request package?

A physician attestation is not required, but can be submitted in place of the PCS if it meets the criteria of a PCS. However, it would only be valid for 60 days from the date of the physician's signature. Submitting only an attestation statement in addition to the PCS does not establish medical necessity; medical documentation must be attached that supports the PCS and/or physician attestation. The medical documentation must describe the beneficiary's condition(s) that necessitate(s) the type and level of ambulance transports.

42. What should ambulance suppliers do if the certifying physician will not provide the additional documentation?

CMS created an informational letter directed towards physicians that is available for download on the ambulance prior authorization website. Ambulance suppliers can give the letter to certifying physicians reminding them of their responsibility to provide the medical record documentation that supports the Physician Certification Statement.

If the physician and/or facility will still not provide the documentation, ambulance suppliers should notify their MAC or CMS (at AmbulancePA@cms.hhs.gov) of the physicians and/or facilities. Physicians and/or facilities who show patterns of non-compliance with this requirement, including those physicians and/or facilities whose records are inadequate or incomplete, may be subject to increased reviews, such as through provider-specific probe reviews.

More Information

43. Where can Medicare beneficiaries who do not qualify for coverage of repetitive, scheduled non-emergent ambulance transport obtain information on alternative transportation?

Medicare beneficiaries can ask other programs that they may be a part of, like Medicaid or Programs of All-inclusive Care for the Elderly (PACE), if they qualify for their help with transportation coverage.

Medicare beneficiaries can also contact Eldercare at 1-800-677-1116 or their local State Health Insurance Assistance Program to ask about other state and local services that can help.

44. Where can I find additional information on the RSNAT Prior Authorization Model?

You can find additional information and educational materials, including an operational guide, on the CMS RSNAT Prior Authorization Model website at <http://go.cms.gov/PAAmbulance>.

45. Where can I send additional questions?

You can send additional questions on the model to CMS at AmbulancePA@cms.hhs.gov.