



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

Special Open Door Forum: October 28, 2021



Model's Purpose

- ▶ Establishes a prior authorization process for RSNAT services to Medicare Fee-for-Service beneficiaries rendered by independent ambulance suppliers.
- ▶ Ensures that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments to protect the Medicare Trust Fund by granting provisional affirmation for a service prior to submission of the claim.

History

- ▶ Began as a CMS Center for Medicare and Medicaid Innovation Center model under section 1115A of the Social Security Act (the Act).
- ▶ Section 1115A allows CMS to test “innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care”.
- ▶ Started in:
 - New Jersey, Pennsylvania, and South Carolina in December 2014
 - Delaware, Maryland, North Carolina, Virginia, West Virginia, and the District of Columbia in January 2016

Nationwide Expansion Criteria

- ▶ Section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) added paragraph (16) to section 1834(l) of the Act, which requires that the Secretary expand the model nationally to all states if model expansion meets certain statutory requirements for Innovation Center programs. These requirements are described in paragraphs (1) through (3) of section 1115A(c) of the Act:
 - (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; and
 - (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.

Nationwide Expansion Approval

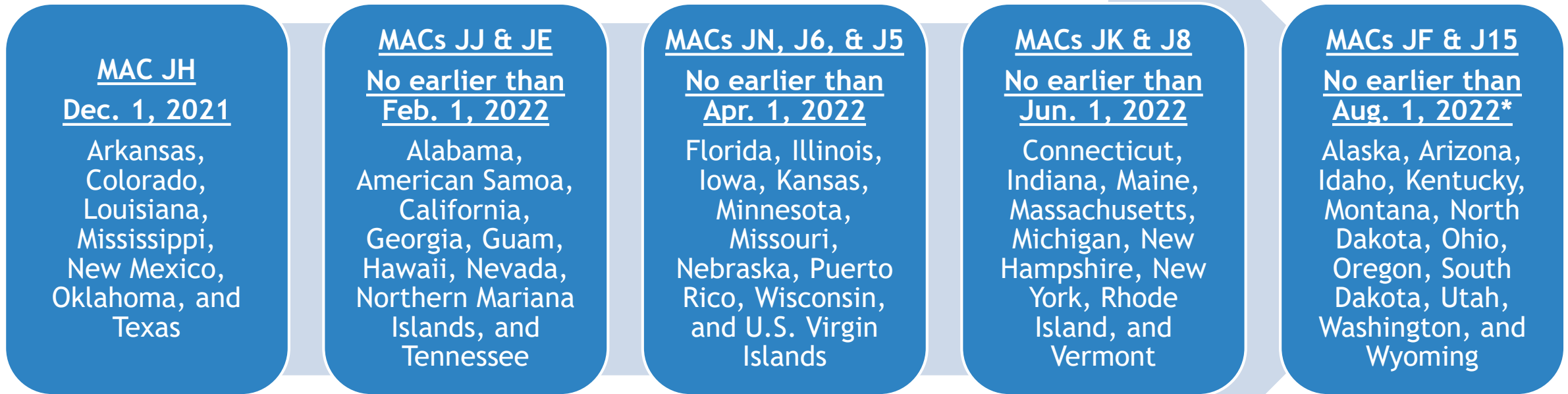
- ▶ The Secretary of Health and Human Services determined that the model met the statutory criteria for expansion.
 - The Chief Actuary of CMS [certified](#) nationwide expansion of the model.
 - The evaluation [reports](#) conducted by CMS contractor, Mathematica Policy Research, found that the model was successful in reducing RSNAT spending and total Medicare spending while maintaining overall quality of and access to care.
 - The Office of Management and Budget approved the information collection burden associated with the model (control number 0938-1380), per the Paperwork Reduction Act.

Nationwide Expansion Announcement

- ▶ On September 22, 2020, CMS [announced](#) that it will expand the RSNAT Prior Authorization Model nationwide, as the model had met all expansion criteria.
- ▶ The model ended under section 1115A authority on December 1, 2020.
 - The model transitioned to authority of section 1834(l)(16) of the Act, as added by section 515(b) of MACRA, on December 2, 2020.
- ▶ The model continued without interruption in the same states of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia.

Implementation Dates

- On August 26, 2021, CMS [announced](#) implementation dates for all remaining states and territories:



*Railroad Retirement Board beneficiaries nationwide will be included in the model no earlier than August 1, 2022.

What is Prior Authorization?

- ▶ A process through which a request for provisional affirmation of coverage is submitted for review before a service is rendered to a beneficiary and before a claim is submitted for payment.
- ▶ Helps to make sure that applicable coverage, payment and coding rules are met before the repetitive non-emergent ambulance transport service is rendered.
- ▶ Some insurance companies, such as TRICARE, certain Medicaid programs, and the private sector, already use prior authorization.



Coverage and Documentation Requirements

- ▶ Medicare coverage policies are unchanged.
- ▶ Documentation requirements are unchanged.
- ▶ Time frames for transport are unchanged.

The model does NOT create any new documentation requirements.

It simply requires the information be submitted earlier in the claims process.

Medical Necessity Requirements

- ▶ Medicare requirements and coverage of ambulance services can be found:
 - [42 CFR 410.40](#)
 - [42 CFR 410.41](#)
 - Medicare Benefit Policy Manual (Pub. 100-02), [Chapter 10](#)
- ▶ Medicare covers ambulance services when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated, to the nearest appropriate facility.
- ▶ 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.
- ▶ The transport must be to obtain a Medicare covered service at a covered destination, or to return from such a service.

Medical Necessity Requirements: Non-Emergent Ambulance

- ▶ The Medicare ambulance benefit for non-emergent transports is very limited and designed only for beneficiaries who are clinically unable to be transported by other means.
- ▶ Non-emergent transportation by ambulance is appropriate if either:
 - The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or
 - The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Medical Necessity Requirements: Bed Confinement

- ▶ For a beneficiary to be considered bed-confined, the following criteria must be met:
 - The beneficiary is unable to get up from bed without assistance.
 - The beneficiary is unable to ambulate.
 - The beneficiary is unable to sit in a chair or wheelchair.
- ▶ Bed confinement is not the sole criterion in determining the medical necessity of non-emergent ambulance transportation; rather, it is one factor that is considered in medical necessity determinations.

Medical Necessity Requirements: Physician Certification Statement (PCS)

- ▶ Medicare may cover repetitive, scheduled non-emergent transportation by ambulance if:
 - All medical necessity requirements are met.
 - 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.
 - The physician's order must be dated no earlier than 60 days before the date the service is furnished.

Additional Coverage Requirements

- ▶ In addition to the medical necessity requirements, the service must meet:
 - All other Medicare coverage and payment requirements
 - Requirements relating to the origin and destination of the transportation
 - Requirements relating to vehicle and staff
 - Requirements related to billing and reporting
- ▶ Medicare covered destinations:
 - Hospital
 - Critical Access Hospital
 - Skilled Nursing Facility (SNF)
 - From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip
 - Beneficiary's home
 - Dialysis facility for end-stage renal disease patient who requires dialysis
 - ❖ A physician's office is NOT a covered destination, except under very limited circumstances.

Definition of Repetitive Ambulance Service

- ▶ Medically necessary ambulance transportation furnished:
 - 3 or more times during a 10-day period
 - or
 - At least once per week for at least 3 weeks.
- ▶ Often needed by beneficiaries receiving dialysis or cancer treatment.

Eligible Participants

Included

- ▶ Independent ambulance suppliers providing:
 - Part B Medicare covered ambulance services
 - Billing on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction

Excluded

- ▶ All hospital-based ambulance providers owned and/or operated by a:
 - hospital
 - critical access hospital
 - SNF
 - comprehensive outpatient rehabilitation facility
 - home health agency,
 - hospice
- ▶ Transports included in a Part A bundled payment
- ▶ Ambulance suppliers under review by a Unified Program Integrity Contractor (UPIC)

Procedure Codes

- ▶ The following Healthcare Common Procedure Coding System 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
- ▶ The mileage code, A0425, does not require prior authorization.
 - It is paid only when either A0426 or A0428 is covered.
 - Should be billed on the same claim as the transport code.

Benefits of Prior Authorization

- ▶ Allows ambulance suppliers and beneficiaries to know BEFORE THE SERVICE IS RENDERED whether Medicare will pay for the service.
- ▶ Allows ambulance suppliers to address issues with claims prior to claim submission.
 - Unlimited opportunities to correct issues
 - Reduces denials
 - Reduces the need for appeals
- ▶ Reduces time for payment as compared to prepayment review.
- ▶ Provides protection from most future audits.

Beneficiary Impact

- ▶ Beneficiaries will receive a notification of the decision about their prior authorization request.
- ▶ Not Changing:
 - The service benefit
 - Dual eligible coverage
 - Private insurance coverage
 - All Advanced Beneficiary Notice (ABN) policies
 - Claim appeal rights

Prior Authorization Process

Prior Authorization Request Submission

- ▶ The ambulance supplier or the beneficiary may submit the prior authorization request to their MAC.
- ▶ The request can be:
 - Mailed
 - Faxed
 - Submitted through the MAC provider portal
 - Submitted through the Electronic Submission of Medical Documentation (esMD) system*

* More info about Electronic Submission of Medical Documentation (esMD) can be found at www.cms.gov/esMD.

Prior Authorization Request Content

- ▶ Request needs to identify:
 - The beneficiary's name, Medicare Number, and date of birth
 - The certifying physician's name, National Provider Identifier (NPI), and address
 - The ambulance supplier's name, NPI, and address
 - The requestor's name and telephone number
 - Procedure codes
 - Submission date
 - Start of 60-day period
 - Number of transports requested
 - State where the ambulance is garaged
 - Indicate if the request is an initial or resubmission review
 - Indicate if the request is expedited and the reason why

Example of a Prior Authorization Request Form

- ▶ Submitters are encouraged to use their respective MAC's form specifically designed for prior authorization requests, but the use of the form is not required.

PLEASE DO NOT COPY. PLEASE DO NOT USE STAPLES.



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Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports Medicare Part B Fax/Mail Coversheet

(Fields with a red asterisk () are required.)*

Request Type (check one)*: Initial Resubmission Expedite

If you selected "resubmission", please provide previous UTN [redacted]

If you selected "expedite", please explain why the normal time frame jeopardizes the life or health of the beneficiary. Medical documentation must also support the need for an expedited review.*

Number of transports requested (round trip = 2 transports)* [redacted]

Start of 60-day period (mm/dd/yyyy)* [redacted]

Procedure code(s)* [redacted] Modifier 1 [redacted] Modifier 2 [redacted]

Ambulance Supplier Information

Supplier Name* [redacted]

Supplier NPI* [redacted] Supplier PTAN [redacted]

Supplier Address* [redacted]

Supplier City, State Zip* [redacted]

State where ambulance is garaged* [redacted]

Beneficiary Information

Last Name* [redacted] First Name* [redacted]

Medicare Beneficiary Identifier* [redacted]

Date of Birth (mm/dd/yyyy)* [redacted]

Certifying Physician Information

Certifying Physician Name [redacted]

Certifying Physician NPI [redacted] Certifying Physician PTAN [redacted]

Certifying Physician Address [redacted]

Certifying Physician City, State, Zip [redacted]

Requester/Contact Information

Fax number (if a decision letter by fax is requested) [redacted]

Contact Name [redacted] Contact Phone/Ext. [redacted]

Requester Name* [redacted] Requester Phone/Ext.* [redacted]

Requester Signature* [redacted] Date* [redacted]

JM-B-1000



02/2021

Please send this form and all additional documentation to

Fax: (803) 462-2702

P.O. Box 100212

Columbia, SC 29202-3212

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Prior Authorization Request Content Cont.

- ▶ Request needs to include the following documentation:
 - Physician Certification Statement
 - ❖ (A signed physician's order by itself doesn't demonstrate medical necessity.)
 - Documentation from the medical record to support the medical necessity of the transports
 - ❖ (Clear description of the patient's current condition, supporting the need for a transport, dated prior to the date of the transport. This information must be from the patient's clinician, not the ambulance provider.)
 - Information on the origin and destination of the transports
 - Any other relevant document as deemed necessary by the MAC to process the prior authorization

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.
- ▶ 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.

Number of Trips: 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.
 - May affirm up to 120 round trips (240 one-way trips) in a 180-day period.
- ▶ The decision is solely at MAC discretion based on the medical records and previous prior authorization requests.
 - The maximum number of requested trips by the ambulance supplier remains at 40 round trips (80 one-way trips) in a 60-day period.
- ▶ Ambulance suppliers are responsible for maintaining a valid PCS at all times.

Prior Authorization Request Review

- ▶ The MAC will postmark the notification of their decision to the ambulance supplier and the beneficiary within **10 business days** for both initial and resubmitted requests.
 - Initial Request - The first prior authorization request for any 60-day period.
 - Resubmitted Request - Request submitted with additional documentation after the initial prior authorization request was non-affirmed.
 - Resubmissions are unlimited during the prior authorization process.
- ▶ Expedited Reviews
 - Available only when the standard timeframe could jeopardize the life or health of the beneficiary; however, under this model this should be extremely rare.
 - The MAC will make reasonable efforts to communicate a decision within **2 business days**.

Decision Letter



- ▶ The MAC sends a decision letter for each prior authorization review to:
 - Ambulance supplier
 - Beneficiary
- ▶ Decision letters include a unique tracking number (UTN) that must be submitted on the claim.
- ▶ Decision letters with a non-affirmed prior authorization decision also include detailed written explanations outlining which specific policy requirement(s) was/were not met.

Provisional Affirmative Prior Authorization Decision

- ▶ A provisional affirmative decision is a preliminary finding that a future claim likely meets Medicare's coverage, coding, and payment requirements.
- ▶ That claim is linked to the prior authorization decision via the UTN and will be paid as long as all Medicare coding, billing, and coverage requirements are met.
- ▶ A provisional affirmative prior authorization decision does not follow the beneficiary.
 - If multiple ambulance suppliers are providing transports to a beneficiary during the same time period, the prior authorization decision will only cover the ambulance supplier indicated in the request.
- ▶ Only one ambulance supplier is allowed to request prior authorization per beneficiary per time period.
 - If the initial ambulance 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 then submit a prior authorization request for the same beneficiary and must include the required documentation in the submission.

Non-Affirmed Prior Authorization Decision

- ▶ If a prior authorization request is non-affirmed, there are two options:
 1. The submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request with appropriate documentation.
 - Unlimited resubmissions are allowed
 - Prior authorization decisions cannot be appealed
 2. The ambulance supplier can provide the service and submit a claim with the non-affirmative UTN.
 - The claim will be denied
 - All appeal rights are then available
 - If applicable, submit the claim to a secondary insurance

Submitting A Claim: Unique Tracking Number (UTN)

- ▶ MACs will list the UTN on the decision letter.
- ▶ This UTN must be submitted on the claim.
- ▶ When submitting an electronic 837 professional claim:
 - The 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:
 - The UTN must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.
- ▶ The UTN assigned to the transport code should not be included on the mileage code.
 - The mileage code should be billed on the same claim as the transport code.

Prior Authorization Request Timeframe

- ▶ Prior authorization should ideally be requested prior to rendering the transports.
 - Claims for the first three round trips are permitted without prior authorization to allow time to obtain prior authorization.
- ▶ If additional time is needed to obtain an affirmed decision, the ambulance supplier may continue to render the transports.
 - Affirmed prior authorization decisions can retroactively apply to transports if the documentation supports the medical necessity at the time of transport.
 - Claims after the third round trip should be held until the UTN has been received.

What Happens if I Don't Use the Prior Authorization Process?

- ▶ The MAC will stop an applicable claim for prepayment review if submitted without a prior authorization decision.
- ▶ This means that the MAC will make a claim determination before claim payment using the standard Medicare prepayment review process.
 - MAC sends additional request letter and waits 45 days for a response
 - MAC reviews submitted documentation within 30 days
- ▶ Without a prior authorization decision, the supplier and the beneficiary will not know whether Medicare will pay for the service (and the supplier or beneficiary may be financially liable).

CMS strongly encourages ambulance suppliers to use the Medicare prior authorization process.

Scenarios

	Prior authorization request is:	The MAC decision is:	The ambulance supplier chooses to:	The MAC will:
1	Submitted	Affirmative	Render the service and submit a claim with UTN	Pay the claim (as long as all other requirements are met)
2	Submitted	Non-Affirmative	<ul style="list-style-type: none"> a. Render the service and submit a claim with UTN b. Correct error and resubmit the request 	<ul style="list-style-type: none"> a. Deny the claim; All appeal rights are available b. Review the resubmitted request
3	Not submitted	N/A	Render the service and submit a claim	Stop the claim for prepayment review

For More Information

- ▶ Model Web Site: <http://go.cms.gov/PAAmbulance>
 - Latest updates
 - Frequently Asked Questions
 - Operational Guide
 - Letter to the Physician
 - Information on Open Door Forums
- ▶ Email the CMS Prior Authorization Team at AmbulancePA@cms.hhs.gov
- ▶ Contact your MAC



Questions?

List of Acronyms

- ▶ ABN - Advance Beneficiary Notice of Noncoverage
- ▶ CFR - Code of Federal Regulations
- ▶ CMS - Centers for Medicare & Medicaid Services
- ▶ esMD - Electronic Submission of Medical Documentation
- ▶ MAC - Medicare Administrative Contractor
- ▶ MACRA - Medicare Access and CHIP Reauthorization Act of 2015
- ▶ NPI - National Provider Identifier
- ▶ PCS - Physician Certification Statement
- ▶ RSNAT - Repetitive, Scheduled Non-Emergent Ambulance Transport
- ▶ SNF - Skilled Nursing Facility
- ▶ UPIC - Unified Program Integrity Contractor