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Repetitive Scheduled Non-Emergent Ambulance Transports Prior Authorization

5/25/2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presenters

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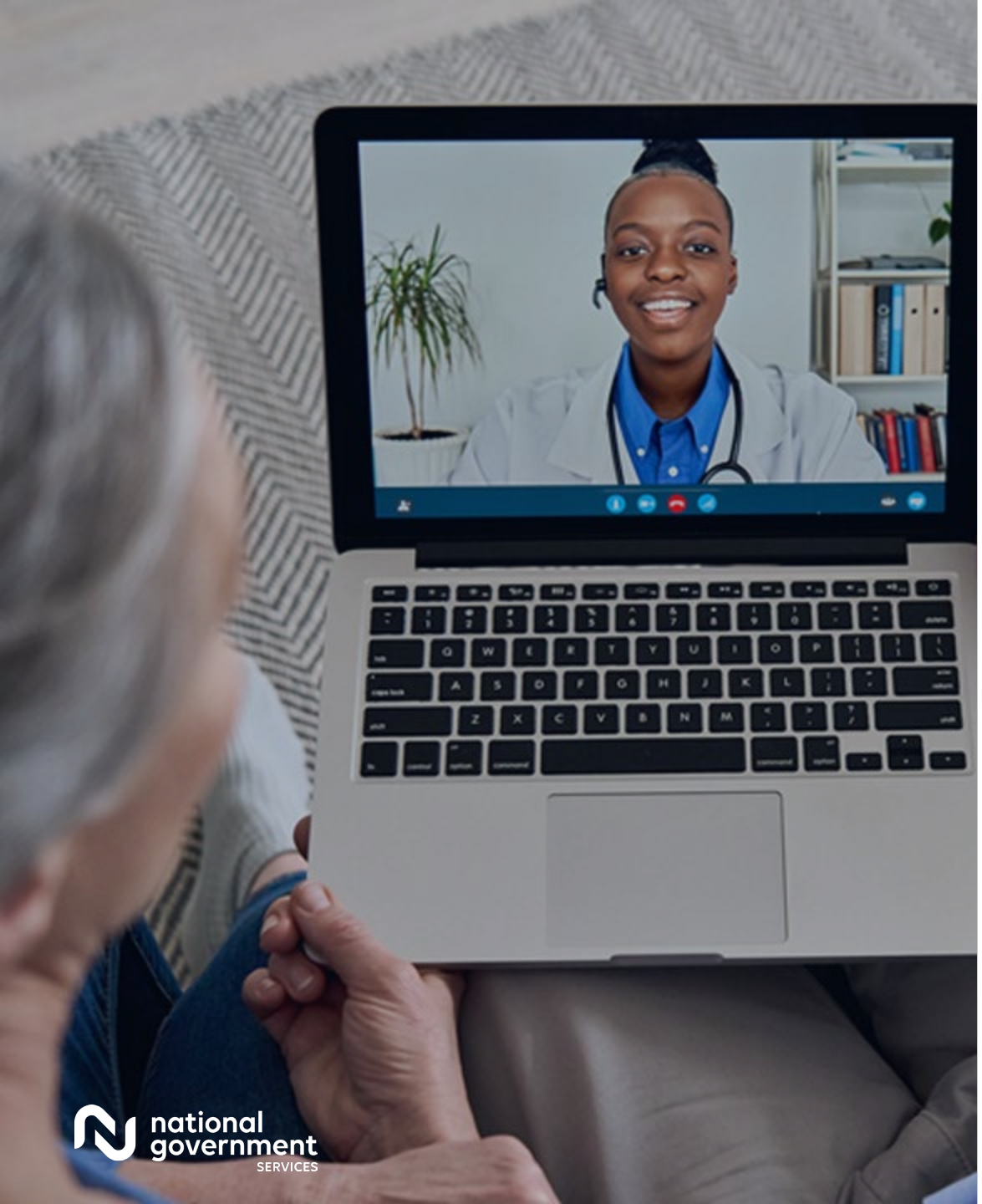

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Objective

To educate the Medicare ambulance community on the Repetitive, Scheduled Non-Emergent Ambulance Transportation prior authorization process.

Agenda

- RSNAT Program
- Medical Necessity
- FAQs
- Test Your Knowledge
- Resources

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RSNAT Prior Authorization Program

Repetitive Ambulance Service Defined

- Medically necessary ambulance transportation that is
  - Furnished in three or more round trips (or six one way trips) during a ten day period, or
  - At least once per week for at least three weeks

Prior Authorization – What Is It?

- A process of receiving provisional or nonaffirmation of coverage before service is rendered
  - Helps ensure applicable coverage, payment and coding rules are met
  - Not required – claims will suspend for prepayment review

Overall Program Goal

- To ensure beneficiaries receive medically necessary care
  - While reducing spending
  - Minimizing risks of improper payment

Benefits

- Prior authorization does not create new clinical documentation requirements
  - Requires same information necessary to support payment, only earlier in the process
  - Suppliers can address claims prior to rendering services, thus avoiding an appeal process
  - Helps ensure requirements are met before service is rendered

Voluntary Process

- Although this is a voluntary process, if prior authorization has not been requested by the fourth round trip, claims will be held for prepayment review
  - An additional documentation request will be sent requesting all relevant documentation to be submitted

Applicable Codes

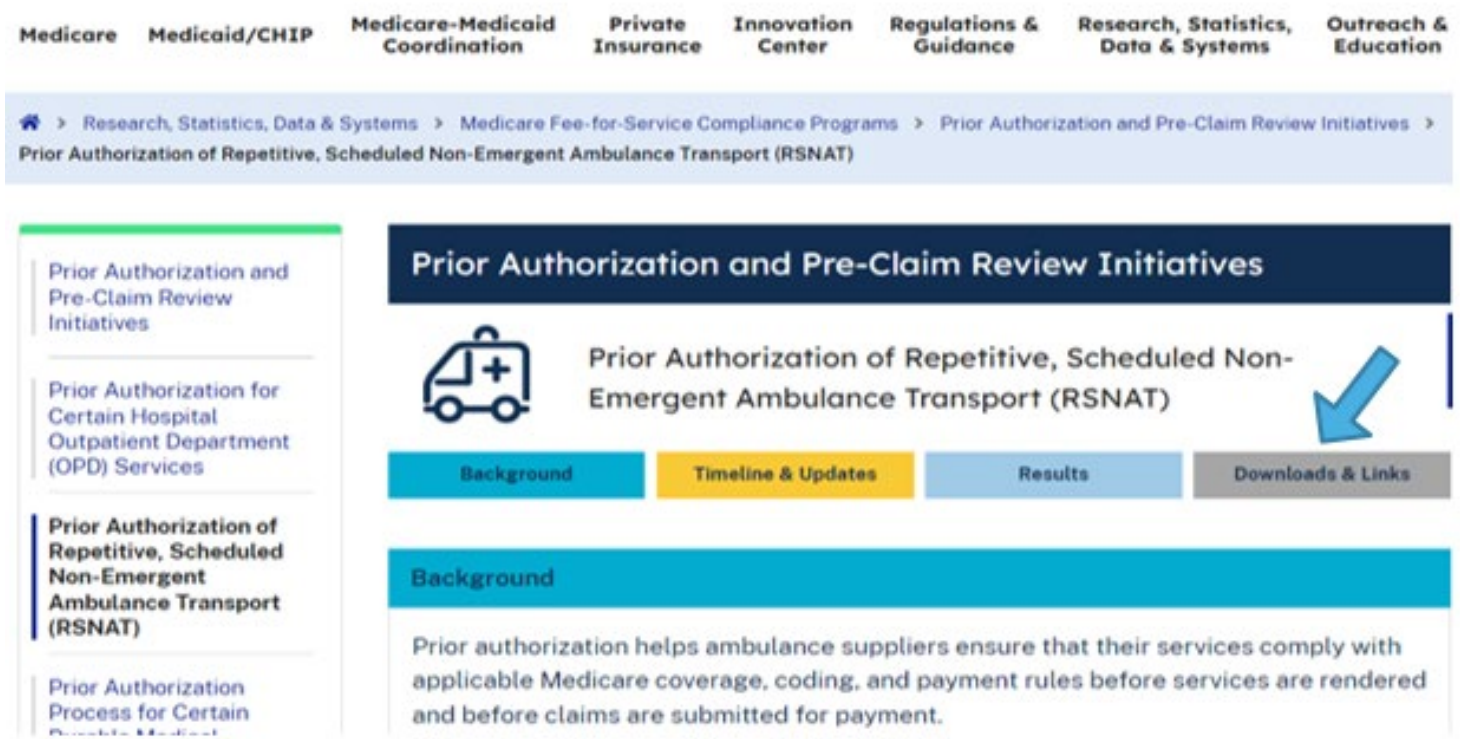
- Program applies to the following HCPCS codes
  - A0428 – BLS nonemergency transport
  - A0426 – ALS nonemergency transport, level 1
  - A0425 – BLS/ALS mileage (associated – does not require prior authorization)

Coverage

- May be covered if
  - Medical necessity requirements are met
    - ✓ Written order obtained from attending physician certifying medical necessity requirements are met
  - Must be dated no earlier than 60 days before date of transport
  - Physician Certification Statement completed
  - Documentation that supports service
    - ✓ This must be obtained prior to furnishing the service

Dear Physician/Practitioner Letter

- CMS Website > RSNAT (in search bar)



Dear Physician/Practitioner Letter, Cont.

Downloads & Links

Downloads

- Ambulance Prior Authorization FAQs (PDF)
- Ambulance Prior Authorization Physician/Practitioner Letter (PDF)
- Ambulance Prior Authorization Operational Guide (PDF)
- Spending and Affirmation Rate Results 10-19-2021 (PDF)
- Spending and Affirmation Rate Results 11-18-2020 (PDF)
- Spending and Affirmation Rate Results 11-08-2019 (PDF)
- Spending and Affirmation Rate Results 10-26-2018 (PDF)
- Spending and Affirmation Rate Results 02-12-2018 (PDF)
- Spending and Affirmation Rate Results 04-07-16 (PDF)
- Example Ambulance Prior Authorization Letter Mailed to Beneficiaries (PDF)

Related Links

- Ambulance Prior Authorization Model Second Interim Evaluation Report
- Ambulance Prior Authorization Model First Interim Evaluation Report
- CMS Partners Fact Sheet (PDF)
- Federal Register Notice Expansion 2020
- Federal Register Notice 1-Year Extension 2019
- Federal Register Notice 1-Year Extension 2018
- Federal Register Notice 1-Year Extension 2017
- Federal Register Notice 2015
- Federal Register Notice 2014
- Final Evaluation Report of the Medicare Prior Authorization Model

Physician Certification Statement

- Must be legibly signed with credentials and dated by attending physician on date completed
  - Patient's name, medical condition, dates of ambulance transportation, required ambulance explanation, NPI/PTAN, address
  - Prefix "Dr." is a title, not a credential
- Stamped signatures/file signatures not acceptable
  - CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 – author with physical disability has to provide proof of their inability to sign due to their disability

Physician Certification Statement

- Cannot be dated more than 60 days in advance of requested start date
- Information must be verifiable
- Medical documentation attached supporting PCS
  - ✓ PCS does not, by itself, demonstrate transports are medically necessary

Medical Record Criteria

- Needs to be
  - Current
  - Legible
  - Specific
  - Patient identification on each page
  - Physician/nonphysician practitioner identification with signature and credentials
  - Must support PCS statement

Medical Record Criteria

- Must be specific
  - Avoid vague statements (“shortness of breath”)
    - ✓ Provide clinical assessment data with findings
- Bed confinement (must meet all three)
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10 describes bed confined as the patient
    - ✓ Cannot get up from bed without assistance
    - ✓ Inability to ambulate
    - ✓ Inability to sit in a chair/wheelchair
  - Clinical assessment data must explain why the patient cannot perform the above on their own

Bed Confined

- A narrative description describing reason term “bed confined” is being used should also be provided, e.g.
  - Requires advanced airway management
  - Requires restraints to prevent injury to self/others
  - Patient morbidly obese which requires additional personnel/equipment to handle

Medical Documentation(1)

- Should provide sufficient information to support prior authorization request and PCS
- Should reveal medical necessity of type/level of transport services
- Reveal exact origin and destination address
- Specify the beneficiary, provider and date of service
- Capture “what” and “why” of patient’s condition
- Should not contradict the PCS

Medical Documentation (2)

- Support ICD-10 diagnoses on PCS with clinical assessment data and objective findings
- Legible
- Dated prior to the requested start date of transports
  - Patients with chronic conditions that do not change – recent medical documentation must be available to indicate chronic or progressively worsening needs

Some Medical Documentation Examples

- Doctor's progress notes
- Nursing notes
- History and physical exam
- Physical/occupational therapy notes
- Home health care notes
- ESRD monthly capitation payment provider notes

Submitting Prior Authorization Request(1)

- Must include all relevant documentation to support coverage
  - PCS
  - Procedure codes
  - Number of transports requested
    - ✓ Note: Prior authorization decision may affirm up to 40 round trips per request in a 60-day period

Submitting Prior Authorization Request(2)

- Medical record documentation supporting medical necessity
- Origin and destination information
- Any other relevant documentation deemed necessary by the A/B MAC

Methods to Submit to Your MAC

- Four options available
  - NGSConnex
  - Electronic Submission of Medical Documentation (esMD)
  - Fax
  - Mail

Mailing Addresses and Fax Numbers

- J6 and JK
  - National Government Services
  - Attn: Medical Review Prior Authorization Request
  - P.O. Box 1708
  - Indianapolis, IN 46207-7108
- Fax
  - J6: 717-565-3840
  - JK: 315-442-4178

Mailing Address – Overnight Mail

- FedEx, UPS, DHL, etc.

  National Government Services, Inc.
  8115 Knue Road
  Indianapolis, IN 46250
  Attn: Mail and Distribution

Timeline For MAC

- MACs will postmark a decision within ten business days – initial and resubmitted requests
  - Excluding federal holidays
  - A resubmitted request is a request resubmitted with additional documentation after the initial prior authorization request was nonaffirmed
- Two business days – expedited request

Number of Trips

- A provisional affirmative PA decision affirms a specified number of trips within a specific amount of time
  - May affirm up to 40 round trips in a 60-day period
  - May affirm less than 40 round trips or 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

Patients With Chronic Conditions

- MACs may consider an extended affirmation period with chronic conditions deemed not likely to improve
  - May affirm up to 120 round trips (240 one-way trips) per request in a 180-day period
  - Suppliers are still responsible for maintaining a valid PCS

Top Reasons for Nonaffirmation

- PCS was not submitted
  - Not signed
  - Missing credentials
  - Incomplete
  - More than 60 days prior to requested start date
- Medical documentation not submitted with PCS
  - Did not support what was included on PCS
  - Did not support patient's condition
  - Did not include patient's name
  - Not legible
  - Dated (not current)

Medical Necessity

“Medically Necessary” Versus “Reasonableness”

- Medical necessity refers to whether the patient medically requires transport by ambulance
  - CMS IOM Publication 100-02, *Medical Benefit Policy Manual*, Chapter 10, Ambulance Services, Section 10.2.1
  - Code of Federal Regulations – 42 CFR 410.40(e)(1)
- Reasonableness refers to whether the transport was appropriate in the first place
  - CMS IOM, Publication 100-02, *Medical Benefit Policy Manual*, Chapter 10, Ambulance Services, Section 10.2.2 – Reasonableness of the Ambulance

Medical Necessity2

- Condition is such that use of any other method of transportation is contraindicated
- Documentation must be kept on file and presented to MAC
- Presence (or absence) of a physician's order for transport by ambulance does not prove (or disprove) whether transport was medically necessary
  - Must meet all program coverage criteria in order for payment to be made

Frequently Asked Questions

FAQ 1.

- How do I know if a PCS is valid?
  - The PCS cannot be dated more than 60 days in advance of the requested start date
  - The attending physician must sign and date the PCS on the day they completed it
  - The PCS cannot be pre or post-dated
  - The PCS cannot be copied to be used repeatedly

FAQ 2.

- How soon can a prior authorization request be submitted?
  - The PCS must indicate the requested start date, and should not be completed any sooner than 60 days in advance

FAQ 3.

- What is the latest date a prior authorization request can be submitted?
  - Suppliers should submit prior authorization requests 10-15 days before the start of the RSNAT, to avoid claim processing delays

FAQ 4.

- What happens if we do not request a prior authorization?
  - For repetitive non-emergent ambulance services, an ADR will be sent by the MAC requesting medical records that support each date of service billed

FAQ 5.

- Is there a tracking number assigned for each prior authorization?
  - Yes, a UTN will be listed on the decision notice and must be submitted on the claim
  - Valid for the affirmed number of trips indicated on the decision letter
  - Invalid UTNs will result in claim denial
  - If additional trips are needed, a new authorization request must be submitted to obtain a new UTN

FAQ 6.

- Where on the claim should the tracking number be written?
  - Electronic 837 – 2300 claim information loop in the Prior Authorization Reference (REF) segment
  - 1500 – Must populate the first 14 positions in item 23

FAQ 7.

- What happens if the patient needs more than 60 days?
  - In order to avoid an expiration of the current authorization, the supplier may submit a subsequent prior authorization request no later than ten business days before the end of the original request
  - The start date should be after the end of the prior 60-day request

FAQ 8.

- Will multiple prior authorizations be required if the patient has more than one medical condition requiring repetitive transport?
  - No – the prior authorization covers up to 40 round trips in a 60-day period, regardless of the treatment they receive at their destination
    - ✓ Transports must be medically necessary
    - ✓ Medical records must support transport

FAQ 9.

- How will I know if the patient already has an existing prior authorization for another ambulance supplier?
  - You should ask the patient – a decision notification copy was also sent to them
  - If you submit a prior authorization request, you will receive a decision letter stating they already have one for the dates requested

FAQ 10.

- What happens if the patient requires more than 40 round trip transports in the 60-day period?
  - The prior authorization covers up to 40 round trips by one supplier per 60-day period. If more transports are needed, a subsequent prior authorization request should be submitted outlining the medical necessity requirements.

FAQ 11.

- What do I do if my prior authorization request was denied?
  - The decision letter will explain why your request was denied. You should take the necessary action required and resubmit.

FAQ 12.

- After the expiration of a prior authorization request, does the physician have to provide new medical record documentation to submit a subsequent request?
  - Medical records should describe the patient's current condition to prove medical necessity
  - PCS should reflect appropriate date(s) and cannot be dated more than 60 days in advance

FAQ 13.

- Who should supply the medical records required for a prior authorization request?
  - The patient's clinician creates and provides the documentation
  - Medical records should not be created by a supplier for the clinician to sign

FAQ 14.

- How do I request an extended affirmation period for patients with chronic conditions?
  - MAC discretion to allow
  - Medical records must indicate condition is chronic
  - MAC must establish through two previous authorization requests the patient's condition has not changed or has deteriorated from previous requests

FAQ 15.

- What do I do if certifying physician does not provide additional documentation?
  - Send provider CMS created information letter to remind them of their responsibility
  - If still not provided, notify MAC or CMS
    - ✓ AmbulancePA@cms.hhs.gov
    - ✓ Physicians/facilities who show pattern of noncompliance may be subject to increased reviews

Test Your Knowledge

Test Your Knowledge #1

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

Test Your Knowledge #2

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

Test Your Knowledge #3

- Are patients in SNFs subject to prior authorization?

Test Your Knowledge #4

- Who completes the PCS?

Test Your Knowledge #5

- Can another ambulance supplier perform the transport if we are not available to perform it?

Test Your Knowledge #6

- If the level of service changes from BLS to ALS, is a new prior authorization required?

Test Your Knowledge #7

- If the PCS is very detailed, will it suffice without medical documentation?

Test Your Knowledge #8

- Does the referring physician on the prior authorization request form have to match the certifying physician on the PCS?

Test Your Knowledge #9

- Who is responsible for submitting the prior authorization request?

Resources

Resources2

- CMS Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport
- Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model Frequently Asked Questions
- RSNAT Prior Authorization Model Physician/Practitioner Letter
- Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model Operational Guide

Questions?

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