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Repetitive Scheduled Non-Emergent Ambulance Transports Prior Authorization

6/15/2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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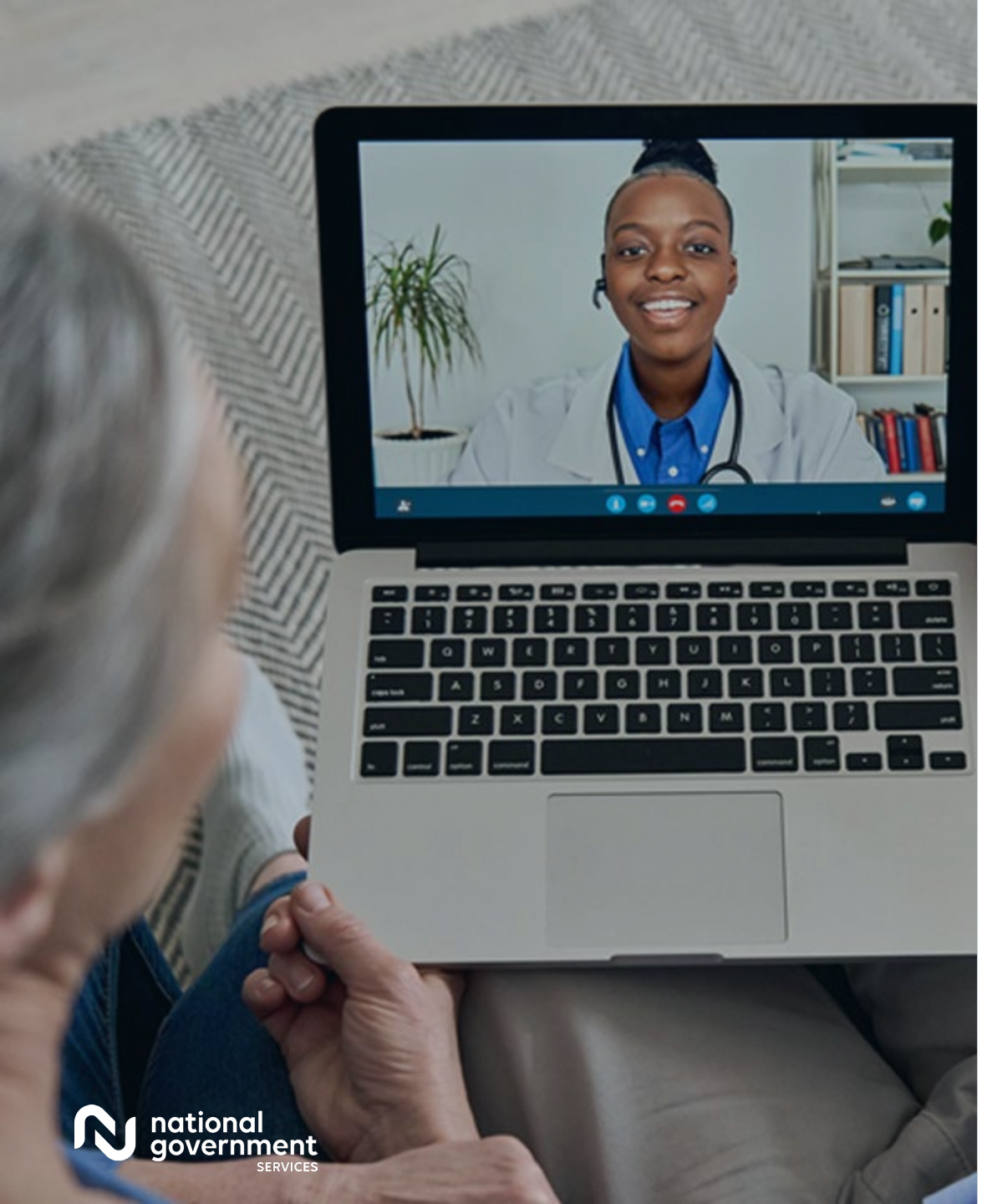

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Objective

To educate the Medicare ambulance community on the Repetitive, Scheduled Non-Emergent Ambulance Transportation (RSNAT) 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
- Each prior authorization decision may affirm up to 40 round trips per request in a 60-day period

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 the 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

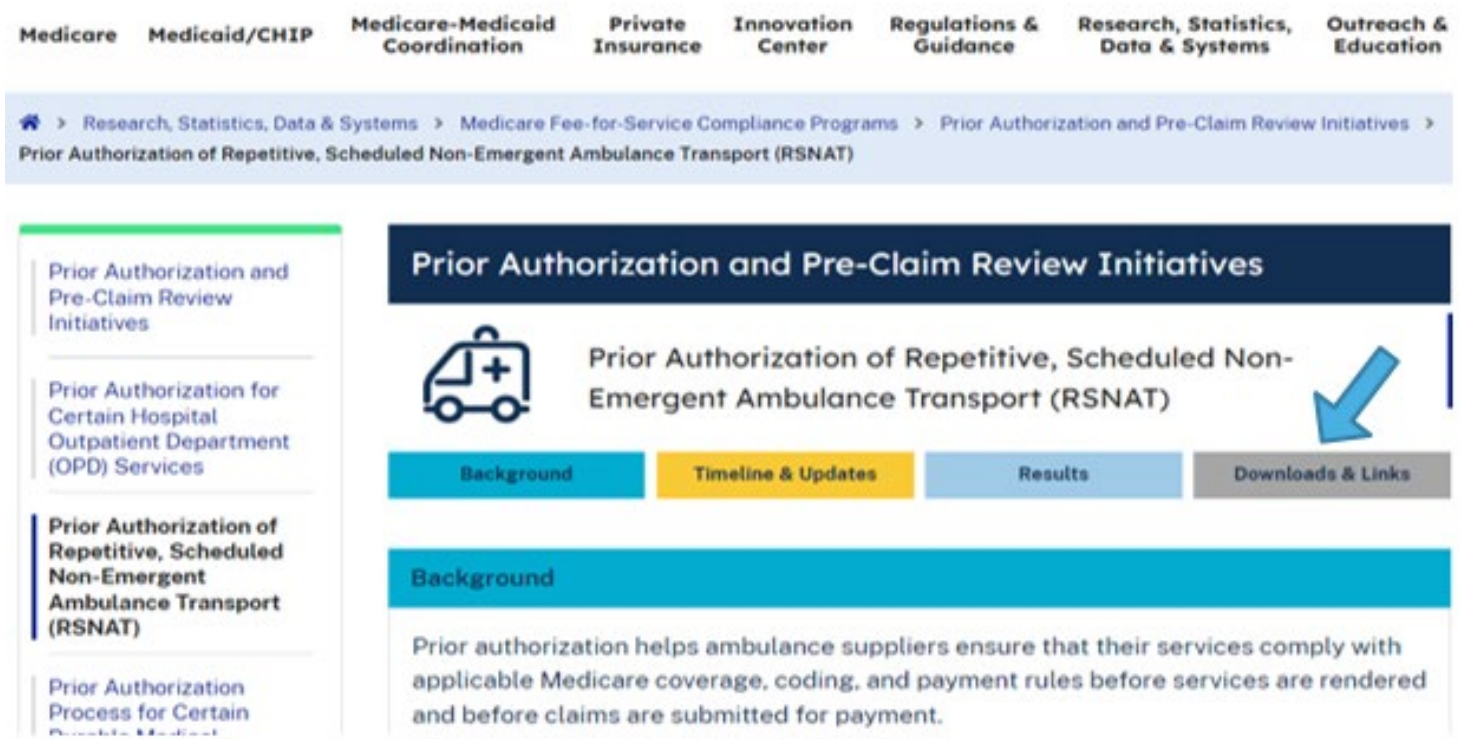
- Program applies to the following HCPCS codes
  - A0428 – BLS nonemergency transport
  - A0426 – ALS nonemergency transport, level 1
  - A0425 – BLS/ALS mileage (associated – does not require prior authorization)

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 (cont.)

- 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 (cont.)

- 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

- 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 (cont.)

- 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 Requests

- 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 Requests (cont.)

- 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 Necessity

- 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 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 2.

- 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 3.

- Where on the claim should the Unique Tracking Number (UTN) , 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 4.

- 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 5.

- 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 6.

- 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 7.

- 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 8.

- 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 9.

- 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 10.

- 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 11.

- What do I do if the 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

- Hospital-based ambulance providers are included in the RSNAT model.
  a. True
  b. False

Test Your Knowledge #2

- Prior authorization is necessary for beneficiaries during a covered Medicare Part A stay.
  - True
  - False

Test Your Knowledge #3

- Transports of Medicare 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.
    a. True
    b. False

Test Your Knowledge #4

- Who completes the Physician Certification Statement (PCS)?
  a. The patient's attending physician
  b. The ambulance supplier
  c. A or B

Test Your Knowledge #5

- Can another ambulance supplier perform the transports if the initial ambulance supplier cannot complete the total number of prior authorized transports?
  a. Yes
  b. No

Test Your Knowledge #6

- If the level of service changes from BLS to ALS, is a new prior authorization required?
  - A. Yes
  - B. No

Test Your Knowledge #7

- If the PCS is very detailed, will it suffice without medical documentation?
  a. Yes
  b. No

Test Your Knowledge #8

- Does the referring physician on the prior authorization request form have to match the certifying physician on the PCS?
  a. Yes
  b. No

Test Your Knowledge #9

- Who is responsible for submitting the prior authorization request?
  a. Ambulance supplier
  b. Medicare beneficiary
  c. Physician of the Medicare beneficiary
  d. Ambulance supplier or Medicare beneficiary
  e. All of the above

Test Your Knowledge #10

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

Test Your Knowledge #11

- Is there a tracking number assigned for each prior authorization?
  a. Yes
  b. No

Test Your Knowledge #12

- Who should supply the medical records required for a prior authorization request?
  a. The patient's clinician
  b. The ambulance supplier
  c. Either a or b

Resources

Resources

- 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?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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