Supporting Statement Part A
Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model Process and Requirements
(CMS-10708/OMB control number: 0938-1380)

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is requesting the Office of Management and Budget (OMB) approval for the renewal of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model.

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. It helps ensure that all relevant coverage, coding, and payment requirements are met. CMS previously tested the RSNAT Prior Authorization Model, in limited states, under the authority of section 1115A of the Social Security Act (the Act). This model tested whether prior authorization of RSNAT services covered under Medicare Part B lowered program spending, while maintaining or improving the quality of care. After determining that the model met all statutory criteria for expansion, CMS began expanding the model through multiple phases on December 1, 2021. The model became fully operational nationwide on August 1, 2022 as the final expansion phase was implemented.

Medicare Coverage

Medicare may cover ambulance services, including air ambulance (fixed-wing and rotary-wing) services, if the ambulance service is furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. 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.

Non-emergent transportation by ambulance is appropriate if either the-- (1) beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or (2) beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, 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.[1]

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips during a 10-day period, or at least 1 round trip per week for at least 3 weeks.[2] Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment.

Medicare may cover repetitive, scheduled non-emergent transportation by ambulance if the-- (1) medical necessity requirements described previously are met; and (2) ambulance supplier, before

[1] 42 CFR 410.40(e)(1)
[2] Program Memorandum Intermediaries/Carriers, Transmittal AB-03-106

furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met (see 42 CFR 410.40(e)(1) and (2)).[3]

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services can be found in 42 CFR 410.40, 410.41, and in the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 10, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf.

Model History

In the November 14, 2014 **Federal Register** (79 FR 68271), CMS published a notice entitled "Medicare Program; Prior Authorization of Repetitive Scheduled Non-emergent Ambulance Transports," which announced the implementation of a 3-year Medicare prior authorization model under the authority of section 1115A of the Act that established a process for requesting prior authorization for RSNAT services rendered by ambulance suppliers garaged in three states (New Jersey, Pennsylvania, and South Carolina). These states were selected as the initial states for the model because of their high utilization and improper payment rates for these services. The model began on December 1, 2014, and was originally scheduled to end in all three states on December 1, 2017.

In the October 23, 2015 **Federal Register** (80 FR 64418), CMS published a notice titled "Medicare Program; Expansion of Prior Authorization of Repetitive Scheduled Non-emergent Ambulance Transports," which announced the inclusion of six additional states (Delaware, the District of Columbia, Maryland, North Carolina, West Virginia, and Virginia) in the RSNAT Prior Authorization Model in accordance with section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10). These six states began participation on January 1, 2016, and the model was originally scheduled to end in all nine model states on December 1, 2017.

In the December 12, 2017 **Federal Register** (82 FR 58400), CMS published a notice titled "Medicare Program; Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports," which announced a 1-year extension of the prior authorization model in all nine model states through December 1, 2018.

In February 2018, CMS released the model's first interim evaluation report[4] conducted by CMS contractor, Mathematica Policy Research, which found that that the model reduced RSNAT service utilization, RSNAT expenditures, and total Medicare expenditures for end-stage renal disease beneficiaries in the model states. The report did not find clear, quantitative impacts on quality, adverse outcomes, or access to care.

In the December 4, 2018 **Federal Register** (83 FR 62577), CMS published a notice titled

[3] Per 42 CFR 410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished.

[4] https://innovation.cms.gov/files/reports/rsnat-firstintevalrpt.pdf

"Medicare Program; Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports," which announced a 1-year extension of the prior authorization model in all nine model states through December 1, 2019.

Section 515(b) of MACRA (Pub. L. 114-10) added paragraph (16) to section 1834(l) of the Act, which requires that, beginning January 1, 2017, the Secretary expand the model to all states if the model expansion meets certain statutory requirements for expanding models that are tested by the Center for Medicare and Medicaid Innovation (Innovation Center) under the authority of section 1115A of the Act. The expansion criteria, described in paragraphs (1) through (3) of section 1115A(c) of the Act, require that:

> (1) the Secretary determines that such expansion is expected to—
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> (A) reduce spending under applicable title without reducing the quality of care; or
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> (B) improve the quality of patient care without increasing spending; and
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> (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.

On March 28, 2018, the Chief Actuary of CMS certified[5] 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.

On May 29, 2019, 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 was 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.

In the September 16, 2019 **Federal Register** (84 FR 48620), CMS published a notice titled "Medicare Program; Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports," which announced a 1-year extension of the prior authorization model in all nine model states through December 1, 2020.

On August 25, 2020, OMB approved the information collection burden association with the national model under OMB control number 0938-1380.

In September 2020, CMS released the Second Interim Evaluation Report[6] conducted by CMS contractor, Mathematica Policy Research, which found that the model was successful in reducing RSNAT spending and total Medicare spending while maintaining overall quality of and access to care. These findings were similar to the First Interim Evaluation Report. In comparison to groups of similar states, the model reduced both RSNAT use and expenditures, by 63 percent and 72

[5] https://www.cms.gov/files/document/certification-medicare-prior-authorization-model-repetitive-scheduled-non-emergent-ambulance.pdf

[6] https://innovation.cms.gov/data-and-reports/2020/rsnat-secondintevalrpt

percent, respectively, in the model states, resulting in a reduction of approximately $550 million in expenditures over four 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.

In the November 23, 2020 **Federal Register** (85 FR 74725), CMS published a notice titled "Medicare Program; National Expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports," which announced the national expansion of the RSNAT Prior Authorization Model with a delay to additional states due the COVID-19 Public Health Emergency. The model continued to operate in the nine states that participated in the model under section 1115A of the Act, which included Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia.

In May 2021, CMS released the Final Evaluation Report[7] conducted by CMS contractor, Mathematica Policy Research, which found that the model was successful in reducing RSNAT and total Medicare spending while maintaining overall quality of and access to care over the first five years of the model. Relative to a comparison group of similar states, the model reduced both RSNAT service use and RSNAT expenditures, by 72% and 76%, respectively, for Medicare beneficiaries with end-stage renal disease and/or severe pressure ulcers in the model states, resulting in a reduction of approximately $750 million in RSNAT service expenditures relative to the comparison group. This decrease in RSNAT service expenditures contributed to a 2.4% ($1 billion over the first five years of the model) decrease in total Medicare Fee-for-Service expenditures among beneficiaries with end-stage renal disease and/or pressure ulcers relative to the comparison group. Overall, the findings suggest that the model had few to no adverse effects on quality of care or access to care.

In the August 27, 2021 **Federal Register** (86 FR 48149), CMS published a notice titled "Medicare Program; National Expansion Implementation for All Remaining States and Territories of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports," which announced the following implementation dates for all remaining states and territories for the national expansion of the RSNAT Prior Authorization Model:

- December 1, 2021 for independent ambulance suppliers garaged in Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas;
- February 1, 2022 for independent ambulance suppliers garaged in Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands and Tennessee;
- April 1, 2022 for independent ambulance suppliers garaged in Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands;
- June 1, 2022 for independent ambulance suppliers garaged in Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont; and
- August 1, 2022 for independent ambulance suppliers garaged in Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming.

National Model Design

The national model follows a similar design as the previous RSNAT Prior Authorization Model

[7] https://innovation.cms.gov/data-and-reports/2021/rsnat-finalevalrpt

that operated under section 1115A of the Act, as described in the September 16, 2019 Federal Register (84 FR 48620). The model applies to independent ambulance suppliers that are not institutionally based providing Part B Medicare covered ambulance services. 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 the model.

There are no changes to the collection requirements or forms required under this collection. The use of prior authorization does not create new clinical documentation requirements. Instead, it requires the same information that ambulance suppliers are already required to maintain to support Medicare payment. Prior authorization also allows ambulance suppliers to address coverage issues prior to furnishing services.

The prior authorization process applies to the following Healthcare Common Procedure Coding System (HCPCS) codes for Medicare payment:

- A0426 Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1).
- A0428 Ambulance service, BLS, non-emergency transport.

While prior authorization is not needed for the mileage code, A0425, a prior authorization decision for A0426 or A0428 will automatically include the associated mileage code.

Submitting a prior authorization request is voluntary. However, the ambulance supplier or beneficiary is encouraged to submit a request for prior authorization along with all relevant documentation to support Medicare coverage of a repetitive, scheduled non-emergent ambulance transport to the Medicare Administrative Contractor (MAC). If prior authorization is not requested, applicable RSNAT claims will be subject to a prepayment medical record review. Claims for the first three round trips (six one-way trips) are permitted to be billed without prior authorization and without being subject to prepayment medical record review.

In order for a prior authorization request to be provisionally affirmed, the request for prior authorization must meet all applicable rules, including any local coverage determination (LCD) requirements for ambulance transport claims. A provisional affirmation is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements. After receipt of all relevant documentation, the MAC will make every effort to conduct a review and postmark the notification of their decision on the prior authorization request within 10 business days. Notification will be provided to the ambulance supplier and to the beneficiary. If a prior authorization request is non-affirmed, the request can be resubmitted with additional documentation. Unlimited resubmissions are allowed.

An ambulance supplier or beneficiary may request an expedited review when the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. If the MAC agrees that the standard review timeframe would put the beneficiary at risk, the MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of all applicable Medicare-required documentation. As this model is for non-emergent services only, we expect requests for expedited reviews to be extremely rare.

A provisional affirmative prior authorization decision may affirm a specified number of trips within

a specific amount of time. 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. Alternatively, a provisional affirmative decision may affirm less than 40 round trips in a 60-day period, or may 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 could 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.

The MAC may consider an extended affirmation period for beneficiaries with a chronic condition that is deemed not likely to improve over time. The prior authorization decision, justified by the beneficiary's chronic condition, may affirm up to 120 round trips (which equates to 240 one-way trips) per prior authorization request in a 180-day period. The medical records must clearly indicate that the 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.

The following describes examples of various prior authorization scenarios:

- Scenario 1: When an ambulance supplier or beneficiary submits a prior authorization request to the MAC with appropriate documentation and all relevant Medicare coverage and documentation requirements are met for the ambulance transports, the MAC will send a provisional affirmative prior authorization decision to the ambulance supplier and the beneficiary. When the subsequent claim is submitted to the MAC by the ambulance supplier, it is linked to the prior authorization decision via the claims processing system, and the claim will be paid so long as all Medicare coding, billing, and coverage requirements are met. A claim could be denied for technical reasons, however, such as a duplicate claim or a date of service after a deceased beneficiary's date of death. CMS contractors may conduct targeted prepayment and post payment reviews to ensure that claims are accompanied by documentation not required or available during the prior authorization process. In addition, it is possible that the Comprehensive Error Rate Testing (CERT) contractor may select a claim linked to an affirmed prior authorization decision for review as the CERT contractor must review a random sample of claims for purposes of estimating the Medicare improper payment rate.

- Scenario 2: When an ambulance supplier or beneficiary submits a prior authorization request, but all relevant Medicare coverage requirements are not met, the MAC will send a non-affirmative prior authorization decision to the ambulance supplier and to the beneficiary advising them that Medicare will not pay for the service. The ambulance supplier or beneficiary may then resubmit the request with additional documentation showing that Medicare requirements have been met. Alternatively, an ambulance supplier could furnish the service and submit a claim with a non-affirmative prior authorization tracking number, at which point the MAC would deny the claim. The ambulance supplier and the beneficiary would then have the Medicare denial for secondary insurance purposes and would have the opportunity to submit an appeal of the claim denial if they think Medicare coverage was denied inappropriately.

- Scenario 3: When an ambulance supplier or beneficiary submits a prior authorization request with incomplete documentation, a detailed decision letter will be sent to the ambulance supplier and to the beneficiary, with an explanation of what information is missing. The ambulance

supplier or beneficiary can rectify the error(s) and resubmit the prior authorization request with appropriate documentation.

- Scenario 4: If an ambulance supplier renders RSNAT services to a beneficiary and does not request prior authorization, then the applicable claims will be stopped for prepayment review and documentation will be requested. Claims for the first three round trips (six one-way trips) are permitted to be billed without prior authorization and without being subject to prepayment medical record review.

++ If the claim is determined to be for services that were not medically necessary or for which there was insufficient documentation, the claim will be denied, and all current policies and procedures regarding liability for payment would apply. The ambulance supplier or the beneficiary, or both, could appeal the claim denial if they believe the denial was inappropriate.

++ If the claim is determined to be payable, it will be paid.

Only one prior authorization request per beneficiary per designated time period can be provisionally affirmed. If the initial ambulance supplier cannot complete the total number of prior authorized transports (for example, the initial ambulance company closes or no longer services that area), the initial request is cancelled. In this situation, a subsequent prior authorization request may be submitted 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 decision would only cover the ambulance supplier indicated in the provisionally affirmed prior authorization request. Any additional ambulance suppliers submitting RSNAT claims for the same beneficiary will be subject to prepayment medical record review.

JUSTIFICATION

1. Need and Legal Basis

Section 515(b) of MACRA (Pub. L. 114-10) added paragraph (16) to section 1834(l) of the Act, which requires that, beginning January 1, 2017, the Secretary expand the RSNAT Prior Authorization 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—
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> (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.

Pursuant to the authority in section 515(b) of MACRA (Pub. L. 114-10), CMS is seeking to renew the necessary approval under the PRA for the collection of information to continue operating the RSNAT Prior Authorization Model. There are no changes to the collection requirements or forms required under this collection.

2. Information Users and Use

The information required under this collection will be used to determine proper payment for repetitive, scheduled non-emergent ambulance transports. The information required in a prior authorization request package includes all medical documents and information to show that the number and level of transports requested are reasonable and necessary for the beneficiary and meet other Medicare requirements. If an ambulance supplier does not submit a prior authorization request and the claim is submitted to the MAC for payment, then the claim will be stopped for prepayment medical record review and medical documentation will be requested. Claims for the first three round trips (six one-way trips) are permitted to be billed without prior authorization and without being subject to prepayment medical record review.

Trained nurse reviewers from the MAC review the information from the ambulance supplier to determine if the beneficiary meets Medicare's requirements for the transport and if the beneficiary needs the level of care requested. The MAC also uses the information to determine if the number of trips requested is reasonable and necessary.

3. Improved Information Techniques

Some of this collection of information could involve the use of electronic or other forms of information technology at the discretion of the submitter. Ambulance suppliers may submit their prior authorization requests and/or other documentation through electronic means. CMS offers electronic submission of

medical documentation (esMD)[8] and the MACs provide an electronic portal for ambulance suppliers to submit their documentation.

4. Duplication and Similar Information

CMS as a whole does not collect this type of information in any existing format, including the medical documentation supporting the need for the transports. With the exception of basic identifying information such a beneficiary name, address, etc., there is no standard form or location where this information can be gathered.

5. Small Businesses

This collection will impact small businesses or other entities to the extent that those small businesses bill Medicare in a manner that triggers review under prior authorization. Ambulance suppliers regardless of size must maintain the necessary documentation to support their claims.

6. Less Frequent Collections

If an ambulance supplier submits a RSNAT claim without a prior authorization decision on file, the claim will be stopped for prepayment medical record review and the ambulance supplier would submit the documentation following receipt of an additional documentation request (ADR). Since RSNAT services are an area of vulnerability in Medicare, less frequent collection of information on these items under prior authorization would be imprudent and undermine the model.

7. Special Circumstances

The frequency of the collection will vary depending on each beneficiary's ambulance transportation needs. Some respondents may need to report information more often than quarterly if they are transporting beneficiaries that require RSNAT services for longer than 60 days.

8. Federal Register Notice

A notice was published in the Federal Register on April 4, 2023 (88 FR 19956). Comments have been addressed in Appendix 1 - Response to Public Comments.

No additional outside consultation was sought.

9. Payments or Gifts to respondents

No payments or gifts will be given to respondents to encourage their response to any request for information under this control number.

10. Confidentiality

The MACs safeguard all protected health information collected in accordance with Health Insurance

[8] www.cms.gov/esMD

Portability and Accountability Act (HIPAA) and Privacy Act standards as applicable.

Medicare contractors have procedures in place to ensure the protection of the health information provided. The HIPAA Privacy Rule allows for the disclosure of health records for payment purposes. Data will be kept private to the extent allowed by law.

11. Sensitive Questions

There are no questions of a sensitive nature associated with this information collection.

12. Burden Estimate

The burden associated with the national model is the time and effort necessary for the submitter to locate and obtain the supporting documentation for the Medicare claim and to forward the materials to the MAC for review. CMS expects that this information would generally be maintained by ambulance suppliers as a normal course of business and that this information would be readily available. CMS anticipates that most submissions will be sent in through fax or by electronic means.[9]

The documentation submitted includes the medical record documentation that supports the medical necessity of the transports, the level of care, the number of transports needed, and that Medicare coverage requirements are met. Ambulance suppliers are currently required to maintain this information on file. The burden for maintaining this information has not been counted for previously.

CMS anticipates clerical staff will collect the information from the medical record and prepare it to be submitted for review. CMS estimates that the average time for office clerical activities associated with this task to be 30 minutes, equivalent to that for prepayment review (OMB Ctrl No 0938-0969).[10] An additional 3 hours of time is estimated for attending educational meetings and reviewing training documents. Average labor costs (including 100 percent fringe benefits) used to estimate the costs are calculated using data available from the Bureau of Labor Statistics. Based on Bureau of Labor Statistics found here (Miscellaneous Healthcare Support Occupations), we estimate an average hourly rate of $18.68 with a loaded rate of $37.26.

[9] Based on historical model data, we estimate:

- 99 percent of prior authorization requests will be submitted electronically and 1 percent will be submitted via mail; and
- 82 percent of ADR submissions will be submitted electronically and 18 percent will be submitted via mail.

[10] The burden estimate reported here will not decrease the burden estimate or the number of prepayment reviews reported in OMB Ctrl No 0938-0969 titled *Medicare Fee-for-Service Early Review of Medical Records*. RSNAT claims that undergo prior authorization will not also undergo prepayment review. If a Medicare review contractor was conducting prepayment review of RSNAT claims prior to the model, they would shift their resources to other claim types.

Table 1: Projected Burden for the RSNAT Prior Authorization Model

Activity	**Responses Per Year (i.e. number of reviewed claims)**[11]	**Time Per Response (hours) or Dollar Cost**	**Total Burden Per Year (hours)**	**Total Burden Costs Per Year Using Loaded Rate**
Prior Authorization Requests and ADR Responses Submitted by Fax or Electronically	Submissions - 65,012 Resubmissions - 11,337	0.5 0.5	32,506 5,668.5	$1,214,424.16 $211,775.16
Prior Authorization Requests and ADR Responses Submitted by Mail	Submissions - 6,910 Resubmissions - 115	0.5 0.5	3,455 57.5	$129,078.80 $2,148.20
Prior Authorization Education – Ambulance Suppliers	1,580[12]	3	4,740	$177,086.40
Prior Authorization Total			**46,427**	**$1,734,512.72**

The projected yearly burden estimate is 46,427 hours and a cost of $1.73 million. This impact is allocated across ambulance suppliers nationally.

13. Capital Costs

CMS estimates the cost of mailing medical records to be $5. CMS offers esMD to ambulance suppliers who wish to use an electronic alternative for sending in medical documents. Additional information on esMD can be found at www.cms.gov/esMD. MACs also provide an electronic portal for ambulance suppliers to submit their documentation. Based on calendar year 2022 model data, CMS estimates there will be 6,910 initial prior authorization requests and ADR submissions mailed during a year. In addition, CMS estimates there will be 115 resubmission prior authorization requests mailed following a non-affirmed decision. Therefore, the total mailing cost is estimated to be $35,125.

[11] The number of responses is based on calendar year 2022 model data. Submissions include initial prior authorization requests and ADR submissions. Resubmissions include prior authorization requests resubmitted after the initial prior authorization request was non-affirmed.

[12] This number represents the number of ambulance suppliers that would potentially participate in educational trainings on the prior authorization process. As this number does not represent responses per year, it is not included in the total responses per year calculation.

Activity	Responses Per Year (i.e. number of reviewed claims)	Time Per Response (hours) or Dollar Cost	Total Costs Per Year
Mailing Costs	Submissions/ Resubmissions - 7,025	$5	$35,125

14. Costs to Federal Government

CMS estimates a yearly cost of approximately $23.2 million to operate the model with an annual 3% inflation rate.

Our cost estimate is based on the anticipated number of prior authorization requests, both initial and resubmissions, that would be submitted; the number of claims skipping prior authorization that would be medically reviewed through the prepayment medical record review process; the number of potential appeals; and the cost of outreach and education to ambulance suppliers, physicians, and beneficiaries.

15. Changes in Burden

At the time of the last burden estimate, the model was only operational in nine states. We used historical claims data to estimate a nationwide burden of 113,706 hours per year (based on 216,941 responses per year). The number of responses per year was calculated from the number of Medicare Fee-for-Service beneficiaries who received RSNAT services in calendar year 2017 with the following assumptions:

- Prior authorization requests will be submitted for 90 percent of beneficiaries receiving RSNAT services.
- Six initial prior authorization requests will be submitted per beneficiary per year, as a prior authorization request can be valid for up to 60 days.
- 25 percent of initial prior authorization requests will be non-affirmed and resubmitted.
- 70 percent of prior authorization requests will be submitted electronically and 30 percent will be submitted via mail.

With the implementation of the nationwide expansion, we used the following nationwide model data from calendar year 2022[13] in lieu of claims data to better estimate the number of responses per year:

- The number of initial prior authorization requests submitted.
- The number of resubmission prior authorization requests submitted.
- The number of ADR responses submitted.
- 99 percent of prior authorization requests were submitted electronically and 1 percent were submitted via mail.
- 82 percent of ADR responses were submitted electronically and 18 percent were submitted via mail.

Based on this updated data, the number of responses per year decreased from our previous estimate of 216,941 to 83,374, which decreased the burden hours per year from 113,706 to 46,427.

[13] If the model was operational for less than 12 months in calendar year 2022 in a state, we extrapolated to obtain a full year's estimate.

16. Publication or Tabulation

There are no plans to publish or tabulate the information collected.

17. Expiration Date

Each instrument displays the expiration date and OMB control number on the first page, top right corner.