mln
FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

# Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model

**What's Changed?**

Note: No substantive content updates.



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

When you get prior authorization for repetitive, scheduled non-emergent ambulance transport (RSNAT) services, standard Medicare coverage rules apply.

Medicare limits the ambulance benefit for non-emergent transports to patients who clinically can't be transported by other means. Under 42 CFR 410.40(e), we cover ambulance services for patients when:

- The medical condition is such that other means of transportation risk patient health
- Both the ambulance transportation itself and the level of service provided (for the billed service) are considered medically necessary
- The transport is for a Medicare-covered service at a covered destination or a return from a Medicare-covered service

Repetitive ambulance service is ambulance transportation you provide with 1 of these:

- Three or more round trips during a 10-day period
- At least 1 round trip per week for 3 weeks

The RSNAT Prior Authorization Model reduces services that don't follow Medicare policy while supporting or improving quality of and access to care.

## Who Can Take Part in This Model?

Independent ambulance suppliers who bill on Form CMS-1500 or a Health Insurance Portability and Accountability Act (HIPAA)-compliant ANSI ASC X12N 837P professional electronic transaction can take part in this model.

## Who Can't Take Part in This Model?

Institution-based Medicare ambulance providers who bill on Form CMS-1450 or the ANSI ASC X12N 837I institutional claim transaction can't take part in this model.

## When Did the Model Start in My Area?

We expanded the model nationwide. See below for the implementation dates for the model.

| States or Areas | Implementation Date |
|---|---|
| New Jersey, Pennsylvania, South Carolina | December 1, 2014 |
| Delaware, the District of Columbia, Maryland, North Carolina, Virginia, West Virginia | December 15, 2015 |
| Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas | December 1, 2021 |
| Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands, Tennessee | February 1, 2022 |
| Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, the U.S. Virgin Islands | April 1, 2022 |
| Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, Vermont | June 1, 2022 |
| Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, Wyoming, Railroad Retirement Board (nationwide) | August 1, 2022 |

## How Do I Request RSNAT Prior Authorization?

RSNAT prior authorization doesn't create new clinical documentation requirements. Instead, it requires you to send your Medicare Administrative Contractor (MAC) the same information necessary to support Medicare payment earlier in the process.

**STEP 1**

**Send your MAC all necessary information.**

- See the RSNAT Prior Authorization Model: Operational Guide, Chapter 5 for the number of trips you can request under prior authorization. Your MAC may authorize:
  - Up to 40 round trips for up to 60 days
  - More than 40 round trips in 60 days with an added prior authorization request
- See the RSNAT Prior Authorization Model: Operational Guide, Chapter 6 for the data you need to include on your request, which includes:
  - Patient information
  - Certifying provider or practitioner information
  - Ambulance supplier information
  - Requestor information
  - Physician certifying statement (PCS)
  - Supporting medical documentation
- Use standard U.S. mail, fax, electronic submission of Medical Documentation (esMD), or the MAC secure internet portal. For esMD submissions, show document type 81 or 8.1. For more information, visit esMD or find your MAC's website.

**STEP 2**

**Your MAC reviews your request.**

After their review, your MAC will issue a provisional affirmative or non-affirmative decision. Your MAC's decision isn't a claim payment decision.

The review can take up to 7 calendar days from the date of the request. The start date for the 7-calendar-day period is the system entry date for prior authorization requests received via esMD or the MAC secure internet portal and the mail room or fax receipt date for paper prior authorization requests.

**STEP 3**

**Your MAC will send you a decision letter within 7 calendar days.**

Your MAC will send you a letter with a unique tracking number via mail, fax, or the MAC secure internet portal. Patients will also get a mailed copy of the decision letter.

**STEP 4**

**Follow the directions in the decision letter.**

### Provisional Affirmative Decision

A provisional affirmative decision means that a future Medicare claim for the service **likely meets** Medicare's coverage, coding, and payment requirements.

After you get this decision:

- Provide services to the patient
- Submit the claim with the unique tracking number
- Maintain all documentation

**Note:** Unified Program Integrity Contractors and MACs may conduct targeted pre-payment and post-payment reviews to make sure claims include documentation that your MAC didn't require for prior authorization.

### Non-Affirmative Decision

A non-affirmative decision explains why a future Medicare claim for the service **doesn't meet** Medicare's coverage, coding, and payment requirements. You can't appeal non-affirmative decisions, but there's no limit to the number of times you may resubmit your request.

After you get this decision, you can either:

- Gather additional documentation as noted in the letter and resubmit the request.
- Submit the claim with the non-affirmative unique tracking number. Your MAC will deny the claim. Then, you may appeal the claim using the normal claims appeal process. See the Medicare Claims Processing Manual, Chapter 29 for information about the appeal process.

**Note:** If applicable, submit the claim to a patient's secondary insurance. See the RSNAT Prior Authorization Model: Operational Guide, Chapter 11 for more information about secondary insurance.

Prior authorization is voluntary, but if you elect to bypass it, applicable RSNAT claims are subject to a pre-payment medical review. You may bill claims for the first 3 round trips without prior authorization and without pre-payment medical review.

## Top Reasons for Non-Affirmative Decisions

If you resubmit prior authorization requests, your MAC will send you and the patient a letter with a decision within 7 days. Follow these tips to avoid a non-affirmative decision:

- Submit a PCS with medical documentation. The PCS must meet these requirements:
  - All sections are complete
  - The patient's attending physician must sign it
  - The PCS includes the physician's credentials
  - The PCS has a date within 60 days **before** the requested start date
- Make sure the medical documentation:
  - Supports what's on the PCS
  - Supports the patient's condition at the requested time of transport
  - Describes the medical necessity of the type and level of transport services by documenting the "what" and "why" of the patient's conditions
  - Includes the patient's name
  - Is clear
  - Is from the patient's clinician and not the ambulance supplier

### HCPCS Codes

The following ambulance HCPCS codes are subject to prior authorization:

- A0426 – Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
- A0428 – Ambulance service, basic life support, non-emergency transport, (BLS)

You don't need prior authorization for the mileage code A0425 as we treat it as an associated procedure. Ambulance suppliers should bill the mileage code on the same claim as the transport code. Payments made for mileage are subject to recoupment if we deny the transport code.

For more information, find your MAC's website.

## Resources

- CY 2023 Physician Fee Schedule Final Rule
- RSNAT Prior Authorization Model Physician/Practitioner Letter – explains the documentation requirements of the ordering physician or practitioner
- Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport – part of CMS's Prior Authorization and Pre-Claim Review Initiatives
- Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model FAQs
- Change Request 13711: Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization (PA) Model Operational Changes Regarding Expedited Requests and Review Timeframes