

National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model

When you get prior authorization for RSNAT services, standard Medicare coverage rules apply. The Medicare ambulance benefit for nonemergent transports is very limited. It's only for patients who clinically can't be transported by other means. Under [42 Code of Federal Regulations \(CFR\) 410.40\(e\)](#), Medicare covers ambulance services for patients when:

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

The RSNAT Prior Authorization Model reduces the use of services that don't comply with Medicare policy while maintaining or improving quality of and access to care. We're expanding the model nationwide.

Repetitive ambulance service is ambulance transportation provided:

- In 3 or more round trips OR
- At least 1 round trip per week for 3 weeks

Who Can Participate in This Model?

Independent ambulance suppliers who bill on a CMS-1500 Form or a HIPAA-compliant ANSI X12N 837P electronic transaction can participate in this model.

Who Can't Participate in This Model?

Institution-based Medicare ambulance providers who bill on the ASC X12 837 institutional claim transaction or Form CMS-1450 can't participate in this model.

When Will the Model Start in My Area?

Nationwide implementation dates for the model are listed below.

States/Areas	Implementation Date
New Jersey, Pennsylvania, South Carolina	Completed December 1, 2014
Delaware, the District of Columbia, Maryland, North Carolina, Virginia, West Virginia	Completed 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?

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 [Chapter 5 of the RSNAT Prior Authorization Model: Operational Guide](#) 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 additional prior authorization request
- See [Chapter 6 of the RSNAT Prior Authorization Model: Operational Guide](#) for the data you need to include on your request. This data includes:
 - Beneficiary information
 - Certifying provider/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 Provider Portal. For esMD submissions, indicate document type 81 or 8.1. For more information, visit the [esMD webpage](#) 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. The MAC's decision isn't a claim payment decision.

The review will take up to 10 business days from the date of the request. If the 10-day time frame risks the health of the patient, you may request that your MAC expedite their review and reply within 2 business days, if possible. However, since this model is for non-emergent services, we expect requests for expedited services to be extremely rare.

Step 3. Your MAC will send you a decision letter within 10 business days.

Your MAC will send you a letter with a unique tracking number via fax, mail, or the MAC provider 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

NOTE: Don't include this number on the mileage code (A0425). The mileage code doesn't need prior authorization, as it's an associated procedure. You should bill the mileage code on the same claim as the transport code.

- Maintain all documentation

NOTE: Unified Program Integrity Contractors (UPICs) and MACs may conduct targeted pre-payment and post-payment reviews to make sure claims include documentation the MAC didn't require for the 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. However, there's no limit on 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, also submit the claim to a patient's secondary insurance. See [Chapter 10 \(Secondary Insurance\) of the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model: Operational Guide](#).

Prior authorization is voluntary; however, if you don't submit a prior authorization request before the fourth round trip in a 30-day period, the related claims are subject to prepayment medical record 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 10 days. There's no limit to how many requests you submit, but you can't appeal a non-affirmative decision. Follow the tips below to avoid the top reasons for non-affirmative decisions:

- Include a PCS with the medical documentation. Make sure it's:
 - Complete
 - Signed by the patient's attending physician
 - Includes credentials
 - Dated less than 60 days before the requested start date
- Make sure the medical documentation:
 - Supports what was 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 condition(s)
 - Includes the patient's name
 - Is clear
 - Is from the patient's clinician and not the ambulance supplier

For more information, [find your MAC's website](#).

Resources

- [Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport](#) – part of CMS' Prior Authorization and Pre-Claim Review Initiatives
- [RSNAT Prior Authorization Model: Operational Guide](#)
- [RSNAT Prior Authorization Model: FAQs](#)
- [Physician/Practitioner Letter \(PDF\)](#) – explains the documentation requirements of the ordering physician/practitioner

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

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