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FACT SHEET
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Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- Clarified repetitive ambulance services criteria (page 2)
- Added language on HCPCS codes subject to prior authorization (pages 5-6)

Substantive content changes are in dark red.

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

The Medicare ambulance benefit for non-emergent transports is very limited. It's only for patients who clinically can't be transported by other means. Under 42 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

Repetitive ambulance service is ambulance transportation you provide with 1 of the following:

- 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 the use of services that don't comply with Medicare policy while maintaining or improving quality of and access to care.

Who Can Participate in This Model?

Independent ambulance suppliers who bill on a CMS-1500 Form or a Health Insurance Portability and Accountability Act (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 Did the Model Start in My Area?

We've expanded the model nationwide. Implementation dates for the model are listed below.

States/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?

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 additional prior authorization request
- See the RSNAT Prior Authorization Model: Operational Guide, Chapter 6, 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, show 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 can 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
- 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 the RSNAT Prior Authorization Model: Operational Guide, Chapter 11 (Secondary Insurance).

Prior authorization is voluntary; however, if you elect to bypass prior authorization, applicable RSNAT claims are subject to a prepayment medical review. You may bill claims for the first 3 round trips without prior authorization and without prepayment 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 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:
  - Is complete
  - Is signed by the patient's attending physician
  - Includes credentials
  - Is dated no more 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 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 (ALS), non-emergency transport, Level 1
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport

Prior authorization isn't needed for the mileage code, A0425. It's treated 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

- Billing and Coding: Ambulance Services
- CY 2023 Physician Fee Schedule (PFS) Final Rule
- Physician/Practitioner Letter (PDF) – explains the documentation requirements of the ordering physician/practitioner
- Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport – part of CMS' Prior Authorization and Pre-Claim Review Initiatives
- RSNAT Prior Authorization Model: FAQs

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