Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Ceners for Medicare & Medicaid Services (CMS)

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This Program Memorandum re-issues AB-00-88, Change Request 1281 dated September 18, 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1281

THE FINAL RULE IMPLEMENTING THE AMBULANCE FEE SCHEDULE HAS NOT YET BEEN PUBLISHED. AS A RESULT, THERE MAY BE CHANGES MADE TO THIS INSTRUCTION IF THE FINAL RULE IS REVISED FROM THE NOTICE OF PROPOSED RULEMAKING (NPRM).

SUBJECT: Implementation of the Ambulance Fee Schedule

BACKGROUND AND GENERAL INFORMATION

This Program Memorandum (PM) instructs intermediaries and carriers about a national ambulance fee schedule. The fee schedule is effective for services furnished on or after January 1, 2001.

Section 4531 (b) (2) of the Balanced Budget Act (BBA) of 1997 added a new §1834 (1) to the Social Security Act which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. This PM provides payment and billing instructions to implement the fee schedule which applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals, skilled nursing facilities and home health agencies.

Section 1834 (l) also requires mandatory assignment for all ambulance services. Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coinsurance amounts.

The fee schedule is effective for claims with dates of service on or after January 1, 2001. Ambulance services covered under Medicare will then be paid based on the lower of the actual billed amount or the ambulance fee schedule amount. As discussed more fully later in this PM, the fee schedule will be phased in over a 4-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers. During the transition period, the supplier’s reimbursement will be based on its current billing methodology.

NEW CATEGORIES OF AMBULANCE SERVICES

Ground Ambulance Services

There are seven categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Throughout this PM “ground” refers to both land and water transportation.)

a. **Basic Life Support (BLS)** - When medically necessary, the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT- Basic, including the establishment of a peripheral intravenous (IV) line.

b. **Basic Life Support (BLS) - Emergency** - When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

c. **Advanced Life Support, Level 1 (ALS1)** - When medically necessary, the provision of an assessment by an advanced life support (ALS) provider or supplier or the provision of one or more ALS interventions. An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

d. **Advanced Life Support, Level 1 (ALS1) - Emergency** - When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

e. **Advanced Life Support, Level 2 (ALS2)** - When medically necessary, the administration of three or more different medications and the provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

f. **Specialty Care Transport (SCT)** - When medically necessary, for a critically injured or ill beneficiary, a level of inter-facility service provided beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training.

g. **Paramedic Intercept (PI)** - Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. For a description of these services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.

<u>Air Ambulance Services</u>

There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

a. **Fixed Wing Air Ambulance (FW)** - Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

b. **Rotary Wing Air Ambulance (RW)** - Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Healthcare Common Procedure Coding System (HCPCS) Codes For New Categories of Service

For ambulance service claims with dates of service on or after January 1, 2001, the applicable HCPCS codes (and their descriptions) are as follows:

- A0425 - Ground mileage, per statute mile
  (Short Description = Ground mileage);

- A0426 - Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
  (Short Description = ALS1);

- A0427 - Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)
  (Short Description = ALSI-Emergency);

- A0428 - Ambulance service, basic life support, non-emergency transport (BLS)
  (Short Description = BLS);

- A0429 - Ambulance service, basic life support, emergency transport (BLS - Emergency)
  (Short Description = BLS-Emergency);

- A0430 - Ambulance service, conventional air services, transport, one way (fixed wing)
  (Short Description = Fixed wing air transport);

- A0431 - Ambulance service, conventional air services, transport, one way (rotary wing);
  (Short Description = Rotary wing air transport);

- A0432 - Paramedic Intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers;
  (Short Description = PI volunteer ambulance co);

- A0433 - Advanced Life Support, Level 2 (ALS2)
  (Short Description = ALS2);

- A0434 - Specialty Care Transport (SCT)
  (Short Description = Specialty care transport);

- A0435 - Fixed wing air mileage, per statute mile
  (Short Description = Fixed wing air mileage); and

- A0436 - Rotary wing air mileage, per statute mile
  (Short Description = Rotary wing air mileage).

NOTE: PI, ALS2, SCT, FW, or RW assumes an emergency condition and, therefore, does not require an emergency designator.

See Attachment B for a crosswalk of new codes to old codes.

CHANGES ASSOCIATED WITH THE FEE SCHEDULE

Items and Services

Payment under the fee schedule for ambulance services:

- Comprises a base rate payment plus a payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Precludes a separate payment for items and services furnished under the ambulance benefit. (An exception to this preclusion exists during the transition period for those billing under Methods 3 and 4. Both topics, the transition and the exception, are discussed further below.)

Payment for items and services is included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing -- but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit.

Jurisdiction

Claims jurisdiction remains unchanged for the duration of the transition to the fee schedule.

Services Provided

Payment is based on the level of service provided, not on the vehicle used. Even if a local government requires an ALS response for all calls, Medicare pays only for the level of service provided and then only when the service is medically necessary.

THE AMBULANCE FEE SCHEDULE

Components of the Ambulance Fee Schedule

The payment amount under the fee schedule is determined as follows:

- <u>For ground ambulance services</u>, the fee schedule amount comprises:

  (1) A money amount that serves as a nationally uniform base rate, called a “conversion factor” (CF), for all ground ambulance services;
  (2) A relative value unit (RVU) assigned to each type of ground ambulance service;
  (3) A geographic adjustment factor (GAF) for each ambulance fee schedule area ((geographic practice cost index (GPCI));
  (4) A nationally uniform loaded mileage rate; and
  (5) For services furnished in a rural area, an additional amount for mileage.

- For air ambulance services, the fee schedule amount comprises:

  (1) A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
  (2) A geographic adjustment factor (GAF) for each ambulance fee schedule area (GPCI);
  (3) A nationally uniform loaded mileage rate for each type of air service; and
  (4) A rural adjustment to the base rate and mileage for services furnished in a rural area.

Discussion of Fee Schedule Components

Ground Ambulance Services

(1) Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF will be updated as necessary.

(2) Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, i.e., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

The RVUs are as follows:

Service Level	RVU
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

(3) Geographic Adjustment Factor (GAF)

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services. The GAF for the ambulance fee schedule uses the non-facility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the ambulance fee schedule are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance ("point of pickup") establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the point of pickup establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the mileage factor.

(4) Mileage

The ambulance fee schedule provides a separate payment amount for mileage. The mileage rate for all types of ground ambulance services, except Paramedic Intercept, is $5 per loaded statute mile.

(5) Adjustment for Mileage for Services Furnished in Rural Areas

Payment is adjusted upward for ambulance services that are furnished in rural areas to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period. For ground ambulance services, the rural adjustment is an increase in the mileage rate of 50% (to $7.50) per loaded statute mile for the first 17 miles.

The point of pickup, as identified by zip code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the zip code of the point of pickup establishes whether a rural adjustment applies to such second (or subsequent) transport.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service Zip code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith modification." (The Goldsmith modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;
- It is located outside of a MSA or NECMA; or
- It is located in a rural census tract of a MSA as determined under the most recent Goldsmith modification.

Presently, one carrier uses the Paramedic Intercept benefit and processes those claims manually to determine rural status.

The CMS will furnish the files that will electronically determine whether a particular zip code is rural or urban. The Fee Schedule and Zip code files are described in Attachment A.

<u>Air Ambulance Services</u>

(1) Base Rates

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services. Also, air ambulance services have no RVUs.

(2) Geographic Adjustment Factor (GAF)

The GAF, as described above for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50% of each of the base rates (fixed and rotary wing).

(3) Mileage

The fee schedule for air ambulance services provides a separate payment for mileage. The mileage rate for fixed wing ambulance services is $6 per loaded statute mile flown. The mileage rate for rotary wing ambulance services is $16 per loaded statute mile flown.

(4) Adjustment for Services Furnished in Rural Areas

Payment is adjusted upward for air ambulance services that are furnished in rural areas. For air ambulance services, the rural adjustment is an increase of 50% to the unadjusted fee schedule amount, i.e., the applicable air service base rate multiplied by the GAF plus the mileage amount.The basis for a rural adjustment for air ambulance services is determined in the same manner as for ground services. That is, whether the point of pickup is within a rural zip code as described above for ground services.

ZIP CODE DETERMINES FEE SCHEDULE AMOUNTS

The point of pickup determines the basis for payment under the fee schedule and the point of pickup is reported by its five-digit zip code. Thus, the zip code of the point of pickup determines both the applicable GPCI and whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the zip code of the point of pickup of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the zip code of the point of pickup must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment.

As discussed more fully below, CMS will provide intermediaries and carriers with a file of zip codes that will map to the appropriate geographic location with a rural designation identified with the letter "R", if appropriate.

OVERVIEW OF THE TRANSITION TO A FEE SCHEDULE

Transition Schedule

Although the fee schedule is effective for ambulance services furnished on or after January 1, 2001, payment under the fee schedule will be phased-in over a 4-year period. Initially, the fee schedule amount will comprise only 20% of the amount allowed from Medicare. The remaining 80% allowed by Medicare for a service furnished in 2001 will be based on the provider's reasonable cost or the supplier's reasonable charge. Thereafter, the fee schedule amount will increase each calendar year as a percentage of the allowed amount until it reaches 100% in year 4. Thus, in year 1, year 2, and year 3, the amount allowed for an ambulance service will be the lower of the submitted charge and a blended rate that comprises both a fee schedule component and a provider's reasonable cost or a supplier's reasonable charge. The phase-in schedule is as follows:

	Fee Schedule Percentage	Cost/Charge Percentage
Year 1 (CY 2001)	20%	80%
Year 2 (CY 2002)	50	50
Year 3 (CY 2003)	80	20
Year 4 (CY 2004)	100	0

Calculating the Blended Rate During the Transition

Payment of ambulance services currently follow one of two methodologies.

- Suppliers are paid based on a reasonable charge methodology.

- Providers are paid based on the provider's interim rate (which is a percentage based on the provider's historical cost-to-charge ratio multiplied by the submitted charge) and then cost-settled at the end of the provider's fiscal year.

For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of both a fee schedule component and a provider or supplier's current payment methodology as follows:

- For suppliers, the blended rate includes both a portion of the reasonable charge and the fee schedule amount. For the purpose of implementing the transition to the fee schedule, the reasonable charge for each supplier is the reasonable charge for 2000 (i.e., the lowest of the customary charge, the prevailing charge and the IIC previously determined for 2000) adjusted for each year of the transition period by the ambulance inflation factor as published by CMS.

- Suppliers using Method 3 or 4 may bill codes A0382, A0384 and A0392 - A0999, as well, as J-codes and codes for EKG testing, for dates of service during the transition period. Methods 3 and 4 will be subject to the phase-in. That is, carriers should apply the appropriate transition year percentage to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the fee schedule, there is no blended amount for these codes.) Deny payment for such codes if billed by a Method 1 biller or Method 2 biller. Do not change any Method 1 or 2 biller to Method 3 or 4.

- Intermediaries must determine both the reasonable cost for a service furnished by a provider and the fee schedule amount that would be payable for the service; then apply the appropriate percentage to each such amount to derive a blended-rate payment amount applicable to the service.

TRANSITION AND PAYMENT FOR SUPPLIERS (CARRIERS)

For claims with dates of service furnished on or after January 1, 2001, pay the lower of the submitted charge or the blended amount determined under the fee schedule transition. For services furnished during 2001, the blended amount is based on 80% of the reasonable charge plus 20% of the ambulance fee schedule amount. For services furnished during 2002, the blended payment amount is based on 50% of the reasonable charge plus 50% of the ambulance fee schedule amount. For services furnished during 2003, the blended payment amount is based on 20% of the reasonable charge plus 80% of the ambulance fee schedule amount.

For 2001, the reasonable charge is the reasonable charge limit for 2000 (i.e., the lowest of the 2000 prevailing charge, customary charge, or IIC) multiplied by the reasonable charge ambulance inflation factor for 2001 (supplied in a separate PM). For 2002, the reasonable charge is the amount determined for 2001 multiplied by the reasonable charge ambulance inflation factor for 2002. For 2003, the reasonable charge is the amount determined for 2002 multiplied by the reasonable charge ambulance inflation factor for 2003. Accordingly, you no longer need to calculate the supplier's reasonable charge based on the usual program procedure.

Send a reasonable charge file to the Railroad Retirement Board, appropriate State Medicaid Agencies, the United Mine Workers, and the Indian Health Service. A reasonable charge update should not be performed for referral to these entities. Instead, send the same reasonable charge data that you developed for 2000, as adjusted by the 2001 ambulance inflation factor.

Claims are processed using the new HCPCS codes created for the ambulance fee schedule. Use the HCPCS crosswalks in Attachment B to determine the reasonable charge amount attributable to the new HCPCS codes. If a supplier bills a new HCPCS code for which there is insufficient actual charge data, then follow the instructions in MCM § 5022ff.

For each ambulance claim, the carrier accesses the zip code file provided by CMS to determine the appropriate locality code for the fee schedule. Only the locality code from the fee schedule should be entered into the claim record in the appropriate field. The CWF edit for locality code will be bypassed for specialty 59 during the transition period. You no longer need to enter the locality code for the reasonable charge with the exception of the items and services payable only by reasonable charge.

To establish a supplier specific reasonable charge for the new HCPCS mileage code A0425, develop an average, i.e., a simple average, not a weighted average, from the supplier specific reasonable charges of the old mileage codes A0380 and A0390. Use that average amount as the reasonable charge for 2001 and update it by the Ambulance Inflation Factor.

Methods 3 and 4 HCPCS for items and supplies, as well as J-codes and codes for EKG testing, will be valid until the transition is completed. Payment for such Method 3 and 4 HCPCS (which is available only to a current Method 3 or Method 4 biller) is based on the reasonable charge for such items and services (80% in 2001, 50% in 2002, and 20% in 2003). The reasonable charge for these HCPCS for each year of the transition is determined in the same manner as described above for ambulance services.

Carrier Coding Requirements for Suppliers

The implementation of the ambulance fee schedule has generated new coding requirements for carrier claims. The following are the concepts from the ambulance fee schedule that require changes in the coding:

- Seven categories of ground ambulance services;
- Two categories of air ambulance services;
- Payment based on the condition of the beneficiary, not on the type of vehicle used;
- Payment is determined by the point of pickup (as reported by the five-digit zip code);
- Increased payment for rural services;
- New HCPCS codes effective for dates of service beginning 1/1/01;
- No grace period for old HCPCS for dates of service after 1/1/01, (**EXCEPTION--**suppliers using Methods 3 and 4 may continue to use the old HCPCS codes for items and services, including J-codes and codes for EKG testing, during the transition period.); and
- Services and supplies included in base rate.

New Suppliers

Continue to use the current enrollment method (CMS-855) to enroll new suppliers, i.e., a supplier who has established a new business or has moved from another carrier jurisdiction as well as suppliers who are billing in other carrier jurisdictions.

Use the "new supplier" procedure that you are currently using to establish a reasonable charge. (See §5010.4.A.4 of the Medicare Carriers Manual (MCM), Part 3.) Treat as a new supplier any supplier currently enrolled with you who does not have a reasonable charge profile.

Carriers may use their discretion to determine which billing method new suppliers may use.

Coding Instructions for Form HCFA-1500

Beginning with dates of service January 1, 2001, the following coding instructions must be used.

- The new HCPCS must be used to reflect the type of service the beneficiary received and not the type of vehicle used.

- There will be no grace period to transition the use of the new HCPCS codes. Return as unprocessable any claim submitted with old HCPCS codes for dates of service January 1, 2001, and later (with the exception of those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill during the transition).

- Suppliers using Method 3 or 4 may use supply codes A0382, A0384 and A0392 - A0999, as well as J-codes and codes for EKG testing, during the transition period.

- In item 23 of form HCFA-1500, code the five-digit zip code of the point of pickup.

  Electronic billers using National Standard Format (NSF) are to report the origin information in record EA1. EA1-06 is used to report the address information. EA1-08 is used to report the city name. EA1-09 is used to report the State code. EA1-10 is used to report the zip code.

  Electronic billers using X-12N 837 (4010) are to report the origin information in loop 2310D (Service Facility Location). NM1 is required. NM101 will have the value '77' (Service Location) and NM102 will have the value '2' (Non-person Entity). The remaining fields are not required. N2 is not required. N3 (Service Facility Location Address) is used to report the address information. N4 (Service Facility Location City/State/Zip) is required. N401 is used to report city name, N402 is used to report the State Code and N403 is used to report the zip code.

- Since the zip code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same zip code. Suppliers must prepare a separate claim for each trip if the points of pickup are located in different zip codes.

- Claims without a zip code in item 23, or with multiple zip codes in item 23, must be returned as unprocessable. Use message N53 on the remittance advice in conjunction with reason code 16.

  Zip codes should be edited for validity.

The format for a zip code is five numerics. If a nine-digit zip code is submitted, ignore the last four digits. If the data submitted in the required field does not match that format, reject the claim.

If the zip code entered on the claim is not in the CMS-supplied zip code file, manually verify the zip code to identify a potential coding error on the claim or a new zip code established by the U.S. Postal Service (USPS). Use the USPS web site at www.usps.com or consult commercially available sources of zip code information. If this process validates the zip code, process the claim. Consider all such zip codes to be urban zip codes until CMS determines that the code should be designated as rural. If this process does not validate the zip code, reject the claim as unprocessable.

- Generally, each ambulance trip will require two lines of coding, i.e., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

- If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1 " as the mileage for trips of less than a mile.

Coding Instructions for CMS-1491

Form CMS-1491 has not been revised for the new fee schedule. The following coding instructions should be followed until the form is revised.

- Enter into item 22 the service HCPCS code, as well as any information necessary to describe the illness or injury.
- The new HCPCS must be used to reflect the type of service the beneficiary received and not the type of vehicle used.
- There will be no grace period to transition the use of the new HCPCS codes. Return as unprocessable any claim submitted with old HCPCS codes for dates of service January 1, 2001, and later (with the exception of those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill through years 1, 2, and 3).
- Generally, a claim for an ambulance service will require two entries, i.e., one HCPCS code for the service and one HCPCS code for the mileage. Suppliers who do not bill mileage would have an entry only for the service.
- Enter into item 14 the mileage HCPCS code, as well as, the number of loaded miles.
- If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1 " as the mileage for trips of less than a mile.
- Suppliers using Method 3 or 4 may use supply codes A0382, A0384 and A0392 - A0999, as well as J-codes and codes for EKG testing, during the transition period. These supply codes should be entered in item 22. Deny claims for items from Method 1 and Method 2 billers.
- The zip code of the point of pickup must be entered in item 12. If there is no zip code in item 12, or if there are multiple zip codes in item 12, return the claim as unprocessable.
- The zip code entered in item 12 must be edited for validity.

The format for a zip code is five numerics. If the zip code in item 12 shows a 9-digit zip code, validate only the first 5 digits. If the zip code entered into item 12 does not correspond to either a USPS 5-digit or 9-digit format, reject the claim as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

If the zip code entered on the claim is not in the CMS-supplied zip code file, manually verify the zip code to identify a potential coding error on the claim or a new zip code established by the U.S. Postal Service (USPS). Use the USPS web site at www.usps.com or consult commercially available sources of zip code information. If this process validates the zip code, process the claim. Consider all such zip codes to be urban zip codes until CMS determines that the code should be designated as rural. If this process does not validate the zip code, reject the claim as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

Using The Fee Schedule

As discussed more fully in a following section, CMS will provide each carrier with two files: a national zip code file and a national ambulance fee schedule file. Each carrier must program a link between the zip code file to determine the locality and the fee schedule file in order to obtain fee schedule amount.

Determine the fee schedule amount based on the fee schedule locality. The fee schedule locality is based on the point of pickup as identified by the zip code that is coded in item 23 of the Form HCFA-1500 or in item 12 of Form CMS-1491. Use the zip code of the point of pickup to electronically crosswalk to the appropriate fee schedule. All zip codes on the zip code file are urban unless identified as rural by the letter “R.”

Determine fee schedule amounts as follows:

C If an urban zip code is reported with a ground or air HCPCS code, determine the amount for the service by using the fee schedule amount for the urban base rate. To determine the amount for mileage, multiply the number of reported miles by the urban mileage rate.

C If a rural zip code is reported with a ground HCPCS code, determine the amount for the service by using the fee schedule amount for the urban base rate. To determine the amount for mileage, multiply the first 17 loaded miles by the urban mileage rate and then multiply this by 1.5, multiply the number of loaded miles in excess of 17 miles by the urban mileage rate, and add the two mileage amounts.

C If a rural zip code is reported with an air HCPCS code, determine the amount for the service by using the fee schedule amount for rural base rate. To determine the amount allowable for the mileage, multiply the number of loaded miles by the rural mileage rate.

For claims with dates of service on or after January 1, 2001 through December 31, 2001, use 20% of the fee schedule amount as determined above and calculate a blended amount by adding 80% of the reasonable charge amount. In years 2 and 3 of the transition, adjust the percentages of both the fee schedule amount and the reasonable charge amount as previously described.

SUMMARY OF CLAIMS ADJUDICATION UNDER THE TRANSITION

The following summarizes the claims adjudication process for ambulance claims during the fee schedule transition period. These steps represent a conceptual model only and are not programming instructions.

- The carrier must establish a 2001 reasonable charge for each supplier. The supplier's 2001 reasonable charge for each HCPCS code for each reasonable charge locality is established by adjusting the reasonable charge for 2000 by the 2001 ambulance inflation factor. The reasonable charges for 2002 and 2003 are established by adjusting the 2001 and 2002 reasonable charges, respectively, by the 2002 and 2003 ambulance inflation factors. Updating a supplier's reasonable charge profile is no longer necessary.

- The carrier must use the CMS-supplied HCPCS crosswalk to establish a crosswalk for each new HCPCS code to each applicable old HCPCS code for each billing method the carrier currently supports. If a carrier currently uses local codes, the carrier must establish their own supplemental crosswalk with respect to any such local codes.

- For each ambulance claim, the carrier accesses the zip code file provided by CMS to determine both the appropriate locality code for the fee schedule and the rural adjustment indicator, if any.

- For each service line item, the carrier uses the service HCPCS code to access the appropriate fee schedule locality to determine the fee schedule amount.

- For each mileage line item with an urban zip code, the carrier uses the mileage HCPCS code and the number of reported miles and multiplies the number of miles by the urban mileage rate specified in the fee schedule file.

- If the HCPCS code is a ground service with a rural zip code (as indicated in the zip code file), then the carrier must multiply the number of miles reported (not to exceed 17 miles) by the urban mileage rate specified in the fee schedule file, then this is multiplied by 1.5. Any miles reported in excess of 17 miles are multiplied by the urban rate.

- If the HCPCS code is an air service with a rural zip code, then the carrier will use the rural service amount and the rural mileage amount.

- The carrier must then add 20% of the fee schedule amount for the service and 80% of the 2001 reasonable charge of the old HCPCS code that crosswalks to the new HCPCS code for the service. The resulting sum is the blended amount for the service. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge.

- The carrier must then add 20% of the fee schedule amount for the mileage and 80% of the 2001 reasonable charge of the old HCPCS code that crosswalks to the new HCPCS code for the mileage (if any). The resulting sum is the blended amount for the mileage. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge.

- If the supplier is a Method 3 or Method 4 biller, and if the supplier submits a charge for a separately billable item or service, the carrier determines the 2001 reasonable charge for the reported HCPCS code for the item and multiplies that amount by 80%. The carrier then compares that amount (because there is no blended amount for separately billable line items) to the submitted charge for that HCPCS code and carries forward the lower of the two amounts.

- The carrier then sums the line item amounts for the service, for the mileage, and, when applicable, for separately billable line items, subtracts the deductible when appropriate, subtracts the coinsurance, and pays the resulting amount.

- For the second year of the fee schedule transition, the blended amount is equal to 50% of the fee schedule amount and 50% of the reasonable charge amount (as updated by the ambulance inflation factor). For the third year of the fee schedule transition, the fee schedule amount is 80% of the blended amount and 20% of the reasonable charge amount (as updated by the ambulance inflation factor).

- Beginning the fourth year, the transition is completed and the amount payable is the lower of 100% of the fee schedule or the submitted charge, subject to any applicable deductible and coinsurance. Also, beginning the fourth year of the transition, all suppliers must begin billing under Method 2. At that time, the carrier must deny claims for separately billable line items. Finally, beginning the fourth year of the transition, claims processing jurisdiction will be determined by the zip code of the point of pickup.

TRANSITION FOR PROVIDERS (INTERMEDIARIES)

The transition begins January 1, 2001, and phases in the fee schedule on a calendar year basis. Therefore, for providers that file cost reports on other than a calendar year basis for cost reporting periods beginning after January 1, 2001, the cost report will be split into two different periods in which two different blended rates apply. For example, (Chart 1 displays graphically the relationship between the overlapping calendar years and fiscal years; Chart 2 describes by fiscal year the reasonable cost transition methodology):

Chart 1

Calendar Year	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004
Cost Reporting Period By Fiscal Year	FY 2001	FY 2002	FY 2003	FY 2004	
Payment Method	Rsble Cost*	Blended Rate			Fee Schedule
Blended Rate (Reasonable Cost/Fee Schedule)		80 / 20	50 / 50	20 / 80	

* Reasonable Cost

Chart 2

Fiscal Year	Cost Reporting Period	Fee Schedule Calendar Year	Payment Method Blended Rates Reasonable Cost/Fee Schedule	Payment Method Dates
2001	July 1, 2000- June 30, 2001		Reasonable Cost Methodology	July 1, 2000 - December 31, 2000
		2001	80% / 20 %	January 1, 2001 - June 30, 2001
2002	July 1, 2001- June 30, 2002	2001	80% / 20 %	July 1, 2001 - December 31, 2001
		2002	50% / 50%	January 1, 2002 - June 30, 2002
2003	July 1, 2002- June 30, 2003	2002	50% / 50%	July 1, 2002 - December 31, 2002
		2003	20% / 80%	January 1, 2003 - June 30, 2003
2004	July 1, 2003- June 30, 2004	2003	20% / 80%	July 1, 2003 - December 31, 2003
		2004	Full Fee Schedule	January 1, 2004 - June 30, 2004

Effective for services furnished during calendar year 2001, the blended amount for provider claims is equal to the sum of 80% of the current ambulance payment system amount (reasonable cost) and 20% of the ambulance fee schedule amount. For calendar year 2002, the blended amount is equal to 50% of the current ambulance payment system amount and 50% of the ambulance fee schedule amount. For calendar year 2003, the blended amount is equal to 20% of the current ambulance payment system amount and 80% of the ambulance fee schedule amount. For calendar year 2004 and beyond, the amount is equal to the full ambulance fee schedule amount.

Payment Requirements for Providers (Intermediaries)

Payment Calculation during Transition

As described above, for claims with dates of service on or after January 1, 2001, and continuing through the transition, pay providers a blended rate which equals the sum of a percentage of the providers' current payment system (reasonable cost) and a percentage of the fee schedule, applicable

to a particular year. Providers will report the appropriate new HCPCS codes described above.

For claims with dates of service from January 1, 2001 through December 31, 2001, pay providers the blended amount, which is calculated based on the sum of the following:

- The provider's interim rate multiplied by the billed charge multiplied by 80% (2001 transition percentage). This payment calculation is the sum of the base rate and mileage payment. These amounts are cost settled at the end of the providers fiscal year and limited by the statutory inflation factor applied to 80% of the providers cost per ambulance trip limit applicable to a particular service (refer to PM A-98-2); and

- 20% of the fee schedule amount that is a combination of the base rate and mileage payment. (Refer to Fee Schedule Payment section below.)

Deduct any applicable Medicare Part B deductible and coinsurance.

For subsequent years, using the basic concept described above, adjust the percentages of the blended rates. For claims with dates of service from January 1, 2002 through December 31, 2002, the blended amount equals the sum of 50% of the current payment system amount and 50% of the fee schedule amount. For claims with dates of service from January 2, 2003 through December 31, 2003, the blended amount equals the sum of 20% of the current payment amount and 80% of the fee schedule amount. For claims with dates of service on or after January 1, 2004, the payment amount equals the ambulance fee schedule amount.

Beginning 2001 all reasonable charge amounts from the old system will be updated using the inflation factor provided in the law except for new providers (see below). (This is the maximum allowance permitted by law.) You will no longer calculate the providers cost per trip based on the provider's costs and number of ambulance trips per PM A-98-2. Instead, the next year's cost per trip limit is equal to the current year's limit updated by the ambulance inflation factor as published by CMS.

New Providers

New providers do not have a cost per trip from the prior year. Therefore, there is no cost per trip inflation limit applied to new providers in their first year of furnishing ambulance services.

Calculation of Fee Schedule Payment during Transition

Pay providers based on the geographic location where the beneficiary is placed onto the ambulance (point of pickup). Use the five-digit zip code of the point of pickup to identify this location. Code this information in field locator 39-41 (Value Code) using A0 (zero) and the related five-digit zip code on Form HCFA-1450.

Electronically crosswalk the zip code to the appropriate carrier locality using the zip code mapping file designating rural areas which we will supply to you. Consider all zip codes on the list urban unless identified as rural (indicated with the letter "R" after the locality). For correct reimbursement, crosswalk the carrier locality to the corresponding carrier locality code on the fee schedule.

For claims with dates of service from January 1, 2001 through December 31, 2001, pay 20% of the base rate and mileage rate of the fee schedule amounts as follows:

- If an urban zip code is reported in conjunction with a ground or air HCPCS code, pay the urban base rate specific to the HCPCS code reported for that location. In addition, pay for the number of miles reported multiplied by the urban mileage amount specific to the HCPCS reported.

- If a rural zip code is reported for a ground HCPCS code, pay the urban base rate for that location and the rural mileage amount for each of the first 17 loaded miles and the urban mileage payment rate for every mile over 17 miles.

- If a rural zip code is reported in conjunction with an air HCPCS code, pay the rural base rate and rural mileage multiplied by the number of miles reported.

For subsequent years, adjust the percentages of the fee schedule amounts as previously described.

Examples

The numbers in the following examples are for illustrative purposes only.

Example 1: In this example, $200 is the provider's billed charges, 90% is the provider's interim rate, and $150 is the full amount (the sum of the base rate and mileage rate) from the fee schedule. Part B deductible has been met.

$200	Provider's billed charges
X 90%	Provider's interim rate
$180	
x 80%	2001 transition percentage
$144	Transition amount
+ 30	20% of the Ambulance Fee Schedule amount of $150
$174	
- 38	Applicable 20% coinsurance*
$136	Reimbursement to provider

*To determine the applicable coinsurance amount:

$200	Provider's billed charge
x 80%	2001 transition percentage
$160	
+ 30	20% of the Ambulance Fee Schedule amount of $150
$190	
x 20%	
$ 38	Beneficiary coinsurance amount

Example 2: All charges and rates are the same as in Example 1. However, the $100 Part B deductible has not been met.

$200	Providers billed charge
x 90%	Providers interim rate
$180	
x 80%	2001 transition percentage
$144	Transition amount
+ 30	20% of the Ambulance Fee Schedule Amount of $150
$174	
- 100	Part B deductible to be met
$74	
- 18	Applicable 20% coinsurance*
$56	Reimbursement to provider

*To determine the applicable coinsurance amount:

$200	Providers billed charge
x 80%	2001 transition percentage
$160	
+ 30	20% of the Ambulance Fee Schedule Amount of $150
$190	
- 100	Part B deductible to be met
$ 90	
x 20%	
$ 18	Beneficiary coinsurance amount

The payment rate for year 2 (2002) is calculated by multiplying the ambulance fee schedule payment rate by 50% and adding the result to 50% of the current payment system amount. The payment rate for year 3 (2003) is calculated by multiplying the ambulance fee schedule by 80% and adding the result to 20% of the current payment system amount. The payment rate for year 4 (2004) is based solely on the ambulance fee schedule.

Billing Requirements for Providers (Intermediaries)

These instructions are for claims with dates of service on or after January 1, 2001. Providers should continue to follow the instructions contained in §3660.1 of the Medicare Intermediary Manual (MIM), Part 3 for claims with dates of service prior to January 1, 2001. (Section 3660.1 of the MIM, Part 3 and companion provider manuals will be updated to reflect these new requirements in future manual instructions.)

Follow the general bill review instructions in §3604 of the MIM. The provider bills you on Form HCFA-1450 or its electronic equivalent.

Applicable Bill Types.--The appropriate bill types are 13X, 22X, 23X, 32X, 33X, 34X, 83X, and 85X.

Value Code Reporting.--Providers must report on every ambulance claim value code A0 (zero) **(National Uniform Billing Committee (NUBC) APPROVED CODE PENDING FINAL RULE)** and the related zip code of the geographic location from which the beneficiary was placed on board the ambulance in Form Locator (FLs) 39-41 "Value Codes." The value code is defined as "Zip code of the location from which the beneficiary is initially placed on board the ambulance." Providers report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter. Providers utilizing the UB-92 flat file use Record Type 41 fields 16 - 39. On the X12 institutional claims transactions, show HI*BE:A0:::12345~, 2300 Loop, HI segment.

More than one ambulance trip may be reported on the same claim if the zip code of all points of pickup are the same. However, since billing requirements do not allow for value codes (zip codes) to be line item specific and only one zip code may be reported per claim, providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different zip codes.

Revenue Code Reporting.--Providers report ambulance services under revenue code 540 in FL 42 "Revenue Code."

HCPCS Reporting.--Providers report the new HCPCS codes established for the ambulance fee schedule as described on page 3. No other HCPCS are acceptable for the reporting of ambulance services and mileage. The new HCPCS must be used to reflect the type of service the beneficiary received and not the type of vehicle used. (For transition purposes and reference see Attachment B for a crosswalk of HCPCS codes. Not all previous HCPCS codes are applicable to providers since providers have been reporting the all-inclusive rate and mileage codes as described in §3660.1.)

Providers must report one of the following HCPCS codes in FL 44 "HCPCS/Rates" for each base rate ambulance trip provided during the billing period: A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434. In addition, they must report one of the following mileage HCPCS codes: A0425, A0435, or A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, providers must report revenue code 540 (ambulance) on two separate and consecutive line items to accommodate both the ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (i.e., a patient is onboard) one-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are NOT reported. Code one mile for trips less than a mile. Miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

Modifier Reporting.--Providers must report an origin and destination modifier for each ambulance trip provided and either a QM (Ambulance service provided under arrangement by a provider of services) or QN (Ambulance service furnished directly by a provider of services) modifier in FL 44 "HCPCS/Rates" as described in §3660.1.D of the MIM.

Line Item Dates of Service Reporting.--Providers are required to report line-item dates of service per revenue code line. This means that providers must report two separate revenue code lines for every ambulance trip provided along with the date of service of each trip.

Service Units Reporting.--For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434**,** providers are required to report in FL 46 "Service Units" for each ambulance trip provided. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0425, A0435, or A0436, providers must also report the number of loaded miles.

Total Charges Reporting.--For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434**,** providers are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0425, A0435, or A0436, providers are to report the actual charge for mileage.

NOTE: There are cases where the provider does not incur any cost for mileage (e.g., a subsidy is received from a local municipality or the transport vehicle is owned and operated by a governmental or volunteer entity, if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene). In these situations, providers report the ambulance trip in accordance to the above instructions. In addition, for purposes of reporting mileage, they report on a separate line item, the appropriate HCPCS code, modifiers, and units. For the related charges, providers report $1.00 in FL 48 "Non-covered Charges."

Edits (Intermediaries)

For claims with dates of service on or after January 1, 2001, install the following edits in your automated claims processing system to assure proper reporting:

- Edit to assure each pair of revenue codes 540 have one of the following ambulance HCPCSs codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 and one of the following mileage HCPCS codes: A0425, A0435, or A0436;

- Edit to assure the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 540;

- Edit to assure that the unit's field is completed for every line item containing revenue code 540;

- Edit to assure that service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal l; and

- Edit to assure on every claim that revenue code 540 is reported, the presence of a value code of A0 (zero) and a corresponding zip code. If the zip code is not a valid zip code in accordance with the U.S. Postal Service assigned zip codes, manually verify the zip code to identify a coding error on the claim or a new zip code from the U.S. Postal Service that is not on the CMS supplied zip code file.

CWF (Intermediaries)

Report the procedure codes in the financial data section (field 65a-65j). Include revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a

separate line. Report the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h "Covered Charges."

Provider Statistics and Reimbursement Report (PS&R) (Intermediaries)

To assure that the providers receive the correct payment amount during the transition period, all submitted charges attributable to ambulance services furnished during a cost-reporting period are aggregated and treated separately from the submitted charges attributable to all other services furnished in the provider. Also, the necessary statistics are maintained for the providers PS&R; this ensures that the ambulance fee schedule portion of the blended transition payment is not cost settled at cost settlement time. See your PS&R guidelines for specific information.

CMS-SUPPLIED FILES FOR IMPLEMENTING THE AMBULANCE FEE SCHEDULE (Intermediaries and Carriers)

CMS will provide you with two files: a zip code file and a national ambulance fee schedule file.

Zip code File

The CMS will provide a file of 5-digit USPS zip codes that will map each zip code to the appropriate fee schedule locality. See Attachment A for the record description of this file. A zip code located in a rural area will be identified with the letter "R." As discussed previously, some zip codes will be designated as rural due to the Goldsmith Modification even though the zip code may be located, in whole or in part, within an MSA or NECMA.

The zip code file will be available via the CMS Mainframe Telecommunications System (formerly referred to as the Network Data Mover). You are responsible for retrieving this file when it becomes available. CMS will furnish full-file replacement updates on a quarterly basis and will notify you when the update files are available for retrieval. The initial zip code file is available now. The file name is: MUOO.@AAA2390.ZIP.LOCALITY.

Ambulance Fee Schedule File

The CMS will also provide a national ambulance fee schedule file that will contain payment amounts for the HCPCS codes listed in this PM. See Attachment A for the record description of this file. The file will include fee schedule payment amounts by locality for all fee schedule localities. The fee schedule file will be available via the CMS Mainframe Telecommunications System. You are responsible for retrieving this file when it becomes available. The full fee schedule amount will be included in this file. CMS will notify you of updates to the fee schedule and when the updated files will be available for retrieval. CMS will send a full-replacement file for annual updates and for any other updates that may occur.

Test File

To assist you in implementing these instructions, CMS will release an ambulance fee schedule test file. This test file is available for retrieval now. The file name is: MUOO.@AAA2390.AMBFS.TEST.V10.

Final Fee Schedule

A final national ambulance fee schedule file is expected to be available by November 30, 2000. The file name is: MUOO.@AAA2390.AMBFS.FINAL.V10.

MISCELLANEOUS PROCEDURAL POLICIES (INTERMEDIARIES AND CARRIERS)

The following additional issues are directly related to the establishment of the ambulance fee schedule and in all cases the applicable blended rate methodology for the transition period will

apply. One or more additional PMs may be issued to address additional issues and provide further clarification.

Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) and Remittance Advice (Intermediaries and Carriers)

Use existing MSN, EOMB and remittance advice messages.

Multiple Patients

An ambulance may transport more than one patient at a time. This may happen at the scene of a traffic accident. In this case, prorate the fee among all the patients in the ambulance. For example, if two patients were transported at one time, and one was a Medicare beneficiary and the other was not, make payment based on one-half of the ambulance fee schedule amount for the level of medically appropriate service furnished to that Medicare patient. Medicare Part B coinsurance, deductible, and mandatory assignment apply to this prorated payment.

Similarly, if both patients were Medicare beneficiaries, payment for each beneficiary would be made based on half of the ambulance fee schedule amount for the level of medically appropriate services furnished to each patient. Medicare Part B coinsurance, deductible, and mandatory assignment apply to these prorated payments.

Effect of Beneficiary's Death

The following three scenarios that apply to payment for ambulance services when the beneficiary dies.

- The beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene: payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing base rate, as applicable, if an air ambulance is dispatched. (For suppliers, there will be only one line item for this situation.) Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Suppliers continue to use the QL modifier.

- The beneficiary is pronounced dead after being loaded into the ambulance (regardless of whether the pronouncement is made during or subsequent to the transport): payment is made following the usual rules of payment as if the beneficiary had not died. This scenario includes a determination of "dead on arrival" at the facility to which the beneficiary was transported.

- No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called.

NOTE: Notwithstanding the beneficiary's apparent condition, the death of a beneficiary should be recognized only when the pronouncement of death is made by an individual who is licensed or otherwise authorized under State law to pronounce death in the State where such pronouncement is made.

Multiple Arrivals

When multiple units respond to a call for services, pay the entity that provides the transport for the beneficiary. The transporting entity bills for all services furnished. For example, if BLS and ALS entities respond to a call and the BLS entity furnishes the transport after an ALS assessment was furnished, the BLS entity will bill using the ALS1 rate. Pay the BLS entity at the ALS1 rate. The BLS entity and the ALS entity settle payment for the ALS assessment. (See MCM §5215.2.) If a potential Paramedic Intercept (PI) service was furnished then see the discussion of PI on page 2. The blended rate methodology applicable to the transition period will otherwise apply.

PROVIDER/SUPPLIER NOTIFICATION (INTERMEDIARIES AND CARRIERS)

Using the information in this PM, notify your providers/suppliers of the implementation of the ambulance fee schedule. Specific, advance notice to individual providers and suppliers, of fee schedule amounts, is not required except as requested by an individual provider or supplier. Furnish general notice to providers and suppliers of the ambulance inflation factor to be applied to their respective year 2000 reasonable charges and of the operation of the fee schedule. The CMS will supply materials to assist you in communicating with providers and suppliers. These materials may be used at your discretion. Also, training and training materials will be provided to you. Training and the distribution of training materials and communication aids are expected to be available beginning in November.

Do not initiate provider training until the NPRM's comment period closes (expected on or about November 12, 2000). Also, all communications with providers and suppliers regarding the implementation of the fee schedule, which occur before the publication of the final rule (expected about December 1, 2000), must specify that CMS's plans for implementing the fee schedule are contingent on the contents of the final rule.

Attachments

The *effective date* for this Program Memorandum (PM) is January 1, 2001.

The *implementation date* for this PM is January 1, 2001.

Funding is available through the regular budget process for costs required for implementation.

This PM may be discarded after December 31, 2002.

If you have any questions, contact the following individuals:

Payment policy and zip codes:	**Glenn McGuirk at (410) 786-5723**
Coverage policy:	**Margot Blige at (410) 786-4642**
Intermediary operational issues:	**Nichole Atkins at (410) 786-8278**
Carrier operational issues:	**Dolores Crujeiras at (410) 786-7169 or Ronalda Leneau at (410) 786-6147**

Attachment A

ZIP CODE FILE

(Record Description)

Field Name	Position	Format	COBOL Description
1. State	1-2	X(02)	State Code
2. Zip code	3-7	X(05)	
3. Carrier	8-12	X(05)	Carrier Number
4. Locality Code	13-14	X(02)	
5. Rural Indicator	15	X	

AMBULANCE FEE SCHEDULE

(Record Description)

Field Name	Position	Format	COBOL Description
1. HCPCS	1-5	X(05)	Common Procedure Coding System
2. Carrier Number	6-10	X(05)	
3. Locality Code	11-12	X(02)	
4. Base RVU	13-18	s9(4)v99	Relative Value Unit
5. Non-Facility PE GPCI	19-22	s9v9(3)	Geographic Adjustment Factor
6. Conversion Factor	23-27	s9(3)v99	Conversion Factor
7. Urban Mileage/ Base Rate	28-34	s9(5)v99	Urban Payment Rate or Mileage Rate (determined by HCPCS)
8. Rural Mileage/ Base Rate	35-41	s9(5)v99	Rural Payment Rate or Mileage Rate (determined by HCPCS)
9. Filler	42-80	X(39)	Future Use

Attachment B

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)	A0030
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)	A0040
A0429	Ambulance service, basic life support (BLS), emergency transport, water, special transportation services	A0050
A0428	Ambulance service, BLS, non-emergency transport, all inclusive (mileage and supplies)	A0300 (Method 1)
A0429	Ambulance service, BLS, emergency transport, all inclusive (mileage and supplies)	A0302 (Method 1)
None	Ambulance service, advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0304
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0306 (Method 1)
None	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0308
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0310 (Method 1)
A0433	Ambulance service, advanced life support, level 2 (ALS2), all inclusive (mileage and supplies)	A0310 (Method 1)
A0434	Ambulance service, specialty care transport (SCT), all inclusive (mileage and supplies)	A0310 (Method 1)
A0428	Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed	A0320 (Method 2)
A0429	Ambulance service, BLS, emergency transport, supplies included, mileage separately billed	A0322 (Method 2)
None	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0324
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0326 (Method 2)
None	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0328
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0330 (Method 2)
A0433	Ambulance service, ALS2, supplies included, mileage separately billed	A0330 (Method 2)
A0434	Ambulance service, SCT, supplies included, mileage separately billed	A0330 (Method 2)
A0428	Ambulance service, BLS, non-emergency transport, mileage included, disposable supplies separately billed	A0340 (Method 3)

A0429	Ambulance service, BLS, emergency transport, mileage included, disposable supplies separately billed	A0342 (Method 3)
None	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed	A0344
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0346 (Method 3)
None	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed	A0348
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0433	Ambulance service, ALS2, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0434	Ambulance service, SCT, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0428	Ambulance service, BLS, non-emergency transport, mileage and disposable supplies separately billed	A0360 (Method 4)
A0429	Ambulance service, BLS, emergency transport, mileage and disposable supplies separately billed	A0362 (Method 4)
None	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0364
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0366 (Method 4)
None	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0368
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0370 (Method 4)
A0433	Ambulance service, ALS2, mileage and disposable supplies separately billed	A0370 (Method 4)
A0434	Ambulance service, SCT, mileage and disposable supplies separately billed	A0370 (Method 4)
A0425	BLS mileage (per mile)	A0380 (averaged with A0390)
None	BLS routine disposable supplies	A0382
None	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	A0384
A0425	ALS mileage (per mile)	A0390 (averaged with A0380)
None	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)	A0392
None	ALS specialized service disposable supplies; IV drug therapy	A0394
None	ALS specialized service disposable supplies; esophageal intubation	A0396

None	ALS routine disposable supplies	A0398
None	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	A0420
None	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	A0422
None	Extra ambulance attendant, ALS or BLS (requires medical review)	A0424
None	Unlisted ambulance service	A0999
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.	Q0186
A0435	Air mileage; FW, (per statute mile)	Local Carrier Code
A0436	Air mileage; RW, (per statute mile)	Local Carrier Code

Definitions of Level of Service

BLS	Basic Life Support (BLS): Where medically necessary, the provision of basic life support (BLS) services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous (IV) line.
ALS1	Advanced Life Support, Level 1 (ALS1): Where medically necessary, the provision of an assessment by an advanced life support (ALS) provider and/or the provision of one or more ALS interventions. An ALS provider is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.
ALS2	Advanced Life Support, Level 2 (ALS2): Where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following ALS procedures: Manual defibrillation/cardioversion, Endotracheal intubation, Central venous line, Cardiac pacing, Chest decompression, Surgical airway, Intraosseous line.
SCT	Specialty Care Transport (SCT): Where medically necessary, in a critically injured or ill patient, a level of inter-facility service provided beyond the scope of the Paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (nursing, medicine, respiratory care, cardiovascular care, or a paramedic with additional training).
PI	Paramedic Intercept (PI): These services are defined in 42 CFR 410.40. They are ALS services provided by an entity that does not provide the ambulance transport . Under limited circumstances, these services can receive Medicare payment.

FW	Fixed Wing Air Ambulance (FW): Fixed wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, fixed wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.
RW	Rotary Wing Air Ambulance (RW): Rotary wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, rotary wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.