

Medicare Claims Processing Manual

Chapter 15 - Ambulance

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(Rev. 1333; Issued: 08-17-07; Effective/Implementation: 10-01-07)

These instructions apply to processing claims to contractors under the ambulance fee schedule (FS).

General rules for coverage of ambulance services are in the Medicare Benefit Policy Manual, Chapter 10. General medical review instructions for ambulance services are in Chapter 6 of the Medicare Program Integrity Manual.

In general, effective April 1, 2002, payment is based on the level of service provided, not on the vehicle used. However, two temporary Q codes (Q3019 and Q3020) are available for use during the transition period when an ALS vehicle is used for a Medicare-covered transport, but no ALS service is furnished.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building. See section 10.3.3 of Chapter 10 of the Medicare Benefit Policy Manual for further details. Refer to section 10.5 of Chapter 3 of the Medicare Claims Processing Manual for additional information on hospital inpatient bundling of ambulance services.

Prior to the implementation of the FS, suppliers used one of four billing methods. Providers used only one billing method, method 2. The FS (effective April 1, 2002) has only one billing method, formerly method 2. This current billing method includes payment for all items and services in the ambulance FS base rate except for the cost of mileage, which is payable separate from the base rate.

NOTE: The cost of oxygen and its administration in connection with and as part of the ambulance service is covered. Under the ambulance FS oxygen and other items and services provided as part of the transport are included in the FS base payment rate and are generally NOT separately payable.

The intermediary is responsible for the processing of claims for ambulance services furnished by providers; i.e., hospitals and skilled nursing facilities. The carrier is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. Effective

December 31, 2000, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH are paid on a reasonable cost basis, but only if the CAH or entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH or entity. Beginning February 24, 1999, ambulance transports to or from a nonhospital-based dialysis facility, origin and destination modifier “J,” satisfy the program’s origin and destination requirements for coverage.

Ambulance supplier services furnished under arrangements with a provider, e.g., hospital or SNF are not billed by the supplier to its carrier, but are billed by the provider to its intermediary. The intermediary is responsible for determining whether the conditions described below are met. In cases where all or part of the ambulance services are billed to the carrier, the carrier has this responsibility, and the intermediary shall contact the carrier to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the intermediary should accept the carrier’s determination without pursuing its own investigation.

Where a provider furnishes ambulance services under arrangements with a supplier of ambulance services, such services can be covered only if the supplier’s vehicles and crew meet the certification requirements applicable for independent ambulance suppliers.

The ambulance FS is effective for claims with dates of service on or after April 1, 2002. The FS is phased in over a transition period through the end of 2005. During the transition period payment amounts are a blended amount: part ambulance FS, and part reasonable charge (for independent suppliers) or reasonable cost for providers. The percentages for the blended rate during the transition period are as follows:

Transition Year	Reasonable Charge/ Cost Percent	FS Percent
Year One (4/1/2002-12/2002)	80	20
Year Two (CY 2003)	60	40
Year Three (CY 2004)	40	60
Year Four (CY 2005)	20	80
Year Five (CY 2006)	0	100

When carriers receive a claim on which the submitted charge substantially exceeds the normal reasonable charge amount for waiting time, they shall send it to the utilization review unit for its review. Once the review unit has made a determination to pay an amount higher than the customary or prevailing charge, documentation to support the reason for this determination **must** accompany the claim.

NOTE: To bill mileage, providers and suppliers continue to use codes A0380 and A0390 for dates of service January 1, 2001 through March 31, 2002.

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. Carriers 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, carriers return the claim as unprocessable.

The ZIP Code entered in item 12 shall 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, carriers validate only the first 5 digits. If the ZIP Code entered into item 12 does not correspond to a USPS either 5- or 9-digit format, carriers 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). ZIP Code information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP Code information may be consulted. If this process validates the ZIP Code, the claim shall be processed. All such ZIP Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP Code, the claim shall be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, ambulance claims submitted with a code(s) that is/are not separately billable and is/are already included in the base rate, contractors shall use Remittance Advice Remark Code N390, "This service cannot be billed separately" and N185, "Do not re-submit this claim/service" with Claim Adjustment Reason Code 97, "Payment was adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." This is true whether the primary transportation service is allowed or denied. When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

10.1 - Assignment

(Rev. 1, 10-01-03)

AB-01-165

For ambulance services furnished on or after April 1, 2002, payment may be made only on an assignment related basis. Therefore, carriers must split all unassigned ambulance claims with dates of service prior to April 1, 2002, if the claim also contains ambulance services furnished on or after April 1, 2002. The latter services must be processed on the basis of assignment.

10.2 - Billing Methods

(Rev. 220, 06-25-04)

AB-00-118, AB-94-8, AB-01-165

As described above, during the transition period ambulance claims are paid based on a blended rate. The FS portion of the rate and the reasonable cost portion of the rate for providers are always billed and paid on the basis of Method 2, as described in the following chart. The reasonable charge portion of the rate for suppliers is paid based on one of the four billing methods shown in the following chart.

Method	Payment
1	Suppliers are paid at an all-inclusive base rate reflecting all services, supplies, and mileage.
2	Suppliers are paid at a base rate to include supplies with a separate charge for mileage.
3	Suppliers are paid at a base rate to include mileage and services but separate charges for supplies.
4	Suppliers are paid at a base rate with separate charges for supplies and mileage.

Effective for dates of service on or after April 1, 2002, with the implementation of the ambulance FS, carriers must ensure that each supplier uses only one billing method. Carriers must give suppliers at least 30 days to make an election. Carriers must convert suppliers using multiple billing methods to one of their current billing methods which the claims processing system supports. In the absence of an election, carriers convert the suppliers using multiple billing methods to billing Method 2.

10.3 - Definitions

(Rev. 220, 06-25-04)

AB-02-130

The following are definitions and applications of items used throughout the ambulance chapter. Refer to the Medicare Benefit Policy Manual, Chapter 10, "Ambulance," for definitions of the levels of service.

Adjusted Base Rate

Definition: Adjusted base rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.

Application: With respect to ground service levels, the adjusted base rate is the payment amount that results from multiplying the conversion factor (CF) by the applicable relative value unit (RVU) and applying the geographic adjustment factor (GAF). With respect to fixed wing and rotary wing services, the adjusted base rate is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the FS and is not calculated by means of a CF and RVU) adjusted by the provider's/supplier's GAF.

Basic Life Support

Definition: Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State or within a State. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Advanced Life Support Assessment

Definition: Advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced Life Support Intervention

Definition: Advanced life support (ALS) intervention is a procedure that is, in accordance with State and local laws, required to be performed by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS intervention applies only to 4ground transports.

EMT-Intermediate

Definition: EMT-Intermediate is an individual who is qualified, in accordance with State and local laws, as an EMT-Basic **and** who is certified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic

Definition: EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with State and local laws, possesses enhanced skills including the ability to administer additional interventions and medications.

Geographic Adjustment Factor

Definition: Geographic adjustment factor (GAF) is a value that is applied to a portion of the unadjusted base rate amount in order to reflect the relative costs of furnishing ambulance services from one area of the country to another. The GAF is equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) from the physician fee schedule.

Application: For ground ambulance services, the GAF is applied to 70 percent of the unadjusted base rate. For air ambulance services, the GAF is applied to 50 percent of the unadjusted base rate.

Goldsmith Modification

Definition: Goldsmith modification is the methodology for the identification of rural census tracts that are located within large metropolitan counties of at least 1,225 square miles but are so isolated from the metropolitan core of that county by distance or physical features as to be more rural than urban in character.

Loaded Mileage

Definition: Loaded mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.

Application: Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates:

1. For ground and water;
2. For fixed wing (FW); and
3. For rotary wing (RW).

For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Point of Pickup (POP)

Definition: Point of pickup is the location of the beneficiary at the time he or she is placed on board the ambulance.

Application: The ZIP Code of the POP must be reported on each claim for ambulance services so that the correct GAF and Rural Adjustment Factor (RAF) may be applied, as appropriate.

Relative Value Units

Definition: Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.

Application: The RVUs for the ambulance FS are as follows:

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

RVUs are not applicable to FW and RW services.

Rural Adjustment Factor (RAF)

Definition: RAF is an adjustment applied to the payment amount for ambulance services when the POP is in a rural area.

Application: For ground ambulance services:

For services furnished before July 1, 2004, a 50 percent increase is applied to the urban ambulance FS mileage rate for each of the first 17 miles of a rural POP. For services furnished on or after July 1, 2004, a 50 percent increase is applied to the rural ambulance FS mileage rate for each of the first 17 miles of a rural POP;

For services furnished before January 1, 2004, a 25 percent increase is applied to the urban ambulance FS mileage rate for mileage between 18 and 50 miles of a rural POP; and the urban ambulance FS mileage rate applies to every mile of a rural POP over 50 miles.

For services furnished during the period January 1, 2004 through June 30, 2004, the urban ambulance FS mileage rate applies to every mile of a rural POP over 17 miles. For services furnished on or after July 1, 2004, the rural ambulance FS mileage rate applies to every mile of a rural POP over 17 miles (and this amount is used when applying the bonus amount for long rural trips, as described below).

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by an amount to be determined by CMS. This increase applies where the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density.

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).

For rural air ambulance services, a 50 percent increase is applied to the total air ambulance fee schedule amount for air services; that is, the adjustment applies to the sum of the adjusted base rate and ambulance fee schedule rate for all of the loaded air mileage.

Services in a Rural Area

Definition: Services in a rural area are services that are furnished:

1. In an area outside a Metropolitan Statistical Area (MSA) except in New England;
2. In New England, outside a New England County Metropolitan Area (NECMA); or,
3. In an area identified as rural using the Goldsmith modification even though the area is within an MSA or NECMA.

Unadjusted Base Rate

Definition: Unadjusted base rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them.

Application: The unadjusted base rate is the payment amount that results from multiplying the CF by the RVU without applying the GAF.

10.4 – Inherent Reasonableness (IR) Provisions for Ambulance

(Rev. 1, 10-01-03)

AB-03-106

Prospective payment systems, including the Ambulance Fee Schedule, are exempt from IR. Therefore, IR applies only to the reasonable charge portion of the blended payment for ambulance services during the transition period. The criteria for applying IR, specified in the final rule, includes a threshold of 15 percent that must be met before IR adjustments may be made. That is, if a payment allowance is determined to be either deficient or excessive by an amount that is less than 15 percent, then no IR adjustment may be made. The CMS has not yet developed contractor processes for applying IR. Until these processes are in place, contractors may not make any IR adjustments.

20 – Intermediary and Carrier Calculation of Payment Amount

(Rev. 220, 06-25-04)

B3-4115, 5116, PM AB-02-131

Medicare covered ambulance services are paid based on the Medicare ambulance fee schedule. The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. There is a transition period, during which time payment will be based on a blended amount based in part on the ambulance fee schedule and in part on reasonable cost (for intermediaries) or reasonable charge (for carriers).

The following subsections describe how intermediaries and carriers calculate the payment amount. Section 20.1 and its subsections describe how the payment amount is calculated for the fee schedule and the transition to the fee schedule. Section 20.2 provides information for payment calculations for claims with dates of service prior to April 1, 2002. The other subsections in §20 provide information on certain components of the payment amount (e.g., mileage) or specialized payment amounts (e.g., air ambulance).

20.1 - Implementation of the Fee Schedule

20.1.1 - General

(Rev. 220, 06-25-04)

Payment under the fee schedule for ambulance services:

- Includes a base rate payment plus a separate 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 for carriers during the transition period for those suppliers billing under Methods 3 and 4.)

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.

For additional information on the fee schedule and its implementation, carriers and intermediaries may refer to “Ambulance Services Education” on the CMS Web site at <http://www.cms.hhs.gov/medlearn/refamb.asp>.

20.1.2 - Jurisdiction

(Rev. 1, 10-01-03)

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

20.1.3 - Services Provided

(Rev. 1, 10-01-03)

AB-03-106

Payment is generally based on the level of service provided, not on the vehicle used.

During the transition period, Medicare allows the ALS-level payment for the reasonable charge portion of the blended rate for emergency and nonemergency transports when an ALS vehicle is used but no ALS service is furnished if no BLS vehicle was available at the time. Two temporary Healthcare Common Procedure Coding System (HCPCS) codes have been established to allow billing for these services during the transition period. HCPCS code Q3019 applies when an ALS vehicle is used for an emergency transport, but no ALS-level service is furnished. HCPCS code Q3020 applies when an ALS vehicle is used for a nonemergency transport, but no ALS level service is furnished. The fee schedule portion of the blended payment is based on the emergency or nonemergency BLS level, as applicable, and the reasonable charge portion of the blended payment is the ALS emergency/nonemergency rate.

The policy of paying according to the medically necessary services actually furnished continues under the Ambulance Fee Schedule. That is, 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 use of Q3019 and Q3020 is effective only during the transition period.

20.1.4 - Components of the Ambulance Fee Schedule

(Rev. 220, 06-25-04)

The mileage rates provided in this section are the base rates that are adjusted by the yearly ambulance inflation factor (AIF). The payment amount under the fee schedule is determined as follows:

- **For ground ambulance services**, the fee schedule amount includes:
 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 locality area (geographic practice cost index (GPCI));
 4. A nationally uniform loaded mileage rate;
 5. An additional amount for certain mileage for a rural point-of-pickup; and

6. For specified temporary periods, certain additional payment amounts as described in section 20.1.4A, below.

- **For air ambulance services**, the fee schedule amount includes:

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 locality 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 for a rural point-of-pickup.

A. 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 is updated annually by the ambulance inflation factor and for other reasons 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, e.g., 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

Service Level	RVU
ALS2	2.75
SCT	3.25
PI	1.75

1. 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 FS uses the nonfacility 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 FS are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance (POP) 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 POP establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70 percent 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 ground mileage rate.

2. Mileage

In the context of all payment instructions, the term “mileage” refers to loaded mileage. The ambulance FS provides a separate payment amount for mileage. The mileage rate per statute mile applies for all types of ground ambulance services, except Paramedic Intercept, and is provided to all Medicare contractors electronically by CMS as part of the ambulance FS. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

3. Adjustment for Certain Ground Mileage for Rural Points of Pickup (POP)

The payment rate is greater for certain mileage where the POP is in a rural area to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period.

If the POP is a rural ZIP Code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. The rural adjustment for ground mileage is 1.5 times the urban mileage allowance for the first 17 loaded miles, and for services furnished before January 1, 2004, 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. For services furnished before July 1, 2004 for all ground miles greater than 50 and for services furnished during the period from January 1, 2004 through June 30, 2004, all ground miles greater than 17, payment is based on the urban rate per mile. For services furnished on or after July 1, 2004 for all ground miles greater than 17, payment is based on the rural rate per mile

(and this amount is used when applying the bonus amount for long rural trips, as described below).

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).

The POP, 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 POP 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 (USPS) ZIP Code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or in New England, 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 an MSA or NECMA; or
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.

See §30.1.1 of Chapter 10 of the Medicare Benefit Policy Manual for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable FS amount for mileage. Thus, when rural mileage is involved, the contractor compares the FS rural mileage payment rate blended with the reasonable cost/charge mileage amount to the provider’s/supplier’s actual charge for mileage and pays the lesser amount.

The CMS furnishes the ambulance FS files electronically, including whether a particular ZIP Code is rural or urban.

4. Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground ambulance transports is subject to a minimum amount. This minimum amount depends upon the area of the country in which the

service is furnished. The country is divided into 9 census divisions and each of the census divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national rate and the regional rate in accordance with the following schedule:

Year	National FS Percentage	Regional FS Percentage
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 – CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. Note that this provision affects only the FS portion of the blended transition payment rate. This floor amount is calculated by CMS centrally and is incorporated into the FS amount that appears in the FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision. However, carriers and intermediaries must continue to apply the appropriate FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period. See section §20.1.6 for the blended percentages to apply during each year of the FS transition period.

5. Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by a percentage amount determined by CMS centrally. This increase applies if the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. CMS will determine this bonus amount and the designated POP rural ZIP Codes in which the bonus applies. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a “B” indicator on the national ZIP Code file. (See Section §20.1.6, “A. Special Instructions for Transition (Intermediaries and Carriers)” for the national ZIP Code file layout and further directions for downloading the file.) Contractors must apply the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP Codes.

6. Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1,

2004 through December 31, 2006. For services furnished where the POP is urban, the rates are increased by 1 percent, and for services furnished where the POP is rural, the rates are increased by 2 percent. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that become effective on July 1, 2004:

Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA

Service	Effective Dates	Payment Increase*
All rural miles	7/1/04 - 12/31/06	2%
Rural miles 51+	7/1/04 - 12/31/08	25% **
All urban miles	7/1/04 - 12/31/06	1%
Urban miles 51+	7/1/04 - 12/31/08	25% **
All rural base rates	7/1/04 - 12/31/06	2%
Rural base rates (lowest quartile)	7/1/04 - 12/31/09	22.6 %**
All urban base rates	7/1/04 - 12/31/06	1%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

NOTES: * All payments are percentage increases and all are cumulative.

**Carrier/intermediary systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file. However, carriers and intermediaries must continue to apply the applicable FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.

B. Air Ambulance Services

1. Base Rates

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

2. Geographic Adjustment Factor (GAF)

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

3. Mileage

The FS for air ambulance services provides a separate payment for mileage.

4. Adjustment for Services Furnished in Rural Areas

The payment rates for air ambulance services where the POP is in a rural area are greater than in an urban area. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted FS amount, e.g., the applicable air service base rate multiplied by the GAF plus the mileage amount or, in other words, 1.5 times both the applicable air service base rate and the total 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 POP is within a rural ZIP Code as described above for ground services.

20.1.5 - ZIP Code Determines Fee Schedule Amounts

(Rev. 220, 06-25-04)

PMs AB-00-88, AB-01-165, Training Book-CH 3, AB-02-131

The POP determines the basis for payment under the FS, and the POP is reported by its 5-digit ZIP Code. Thus, the ZIP Code of the POP 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 POP 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 POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment. Carriers must report the POP ZIP Code, at the line item level, to CWF when they report all other ambulance claim information. CWF must report the POP ZIP Code to the national claims history file, along with the rest of the ambulance claims record.

A. No ZIP Code

In areas without an apparent ZIP Code, it is the provider's/supplier's responsibility to confirm that the POP does not have a ZIP Code that has been assigned by the USPS. If the provider/supplier has made a good-faith effort to confirm that no ZIP Code for the POP exists, it may use the ZIP Code nearest to the POP.

Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the POP does not have an assigned ZIP Code and annotate the claim to indicate that a surrogate ZIP Code has been used (e.g., "Surrogate ZIP Code; POP in No-ZIP"). Providers and suppliers should maintain this documentation and provide it to their intermediary or carrier upon request.

Contractors must request additional documentation from providers/suppliers when a claim submitted using a surrogate ZIP Code does not contain sufficient information to determine that the ZIP Code does not exist for the POP. They must investigate and report any claims submitted with an inappropriate and/or falsified surrogate ZIP Code.

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). ZIP Code information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP Code information may be consulted. If this process validates the ZIP Code, the claim may be processed. All such ZIP Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural, unless the contractor exercises its discretion to designate the ZIP Code as rural. (See Section §20.1.5.B – New ZIP Codes.) If this process does not validate the ZIP Code, the claim must be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

B. New ZIP Codes

New ZIP Codes are considered urban until CMS determines that the ZIP Code is located in a rural area. Thus, until a ZIP Code is added to the Medicare ZIP Code file with a rural designation, it will be considered an urban ZIP Code. However, despite the default designation of new ZIP codes as urban, intermediaries and carriers have discretion to determine that a new ZIP Code is rural until designated otherwise. If the contractor designates a new ZIP Code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment.

Providers and suppliers should annotate claims using a new ZIP Code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP Code and provide it to their intermediary or carrier upon request.

If the provider or supplier believes that a new ZIP Code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare FS regulation), it may request an adjustment from the intermediary or appeal the determination with the carrier, as applicable, in accordance with standard procedures.

When processing a claim with a POP ZIP Code that is not on the Medicare ZIP Code file, contractors must search the USPS Web site at <http://www.usps.com/>, other governmental Web sites, and commercial Web sites, to validate the new ZIP Code. (The Census Bureau Web site located at <http://www.census.gov/> contains a list of valid ZIP Codes.) If the ZIP Code cannot be validated using the USPS Web site or other authoritative source such as the Census Bureau Web site, reject the claim as unprocessable.

C. Inaccurate ZIP Codes

If providers and suppliers knowingly and willfully report a surrogate ZIP Code because they do not know the proper ZIP Code, they may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP Code on a claim

when not appropriate to do so for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

D. Claims Outside of the U.S.

The following policy applies to claims outside of the U.S.:

- Ground transports with pickup and drop off points within Canada or Mexico will be paid at the fee associated with the U.S. ZIP Code that is closest to the POP;
- For water transport from the territorial waters of the U.S., the fee associated with the U.S. port of entry ZIP Code will be paid;
- Ground transports with pickup within Canada or Mexico to the U.S. will be paid at the fee associated with the U.S. ZIP Code at the point of entry; and
- Fees associated with the U.S. border port of entry ZIP Codes will be paid for air transport from areas outside the U.S. to the U.S. for covered claims.

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 and, where appropriate, with a rural designation identified with the letter “R” or “B.” Urban ZIP Codes are identified with a blank in this position.

20.1.6 - Transition Overview

(Rev. 1463, Issued: 02-22-08, Effective: 01-01-09, Implementation: Carriers and A/B MACs Part B Claims: analysis/design 07-07-08, design/production 10-06-08, production/implementation 01-05-09 / FIs and A/B MACs Part A Claims: analysis/design 07-07-08, coding/unit testing 10-06-08, system testing/implementation 01-05-09)

AB-01-185, AB-01-165, AB-02-117

The ambulance FS is subject to a 5-year transition period as follows:

Year	Fee Schedule Percentage	Reasonable Cost/Charge Percentage
Year 1 (4/1/02 - 12/31/02)	20%	80%
Year 2 (CY 2003)	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

Calculating the Blended Rate During the Transition

Before the FS payment of ambulance services followed one of two methodologies.

- Suppliers (carrier claims) were paid based on a reasonable charge methodology; or
- Providers (intermediary claims) were 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 is a blended rate that consists of both a FS 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 FS amount. For the purpose of implementing the transition to the FS, the reasonable charge for each supplier is the reasonable charge for 2000 (i.e., the lowest of the customary charge, the prevailing charge, or the inflation indexed charge (IIC) previously determined for 2000) adjusted for each year of the transition period by the ambulance inflation factor as published by CMS.
- For services furnished during the transition period, suppliers using Method 3 or Method 4 may bill HCPCS codes A0382, A0384, A0392 through A0999, J-codes, and codes for EKG testing. These Method 3 and Method 4 HCPCS codes are subject to the phase-in blending percentages. Therefore, carriers apply the appropriate transition year blending percentage to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the FS, there is no FS portion for these codes.) A similar payment may be made during the transition period for HCPCS codes A0420 and A0424 if billed by a Method 1 biller or Method 2 biller. Carriers do not change any Method 1 or Method 2 biller to Method 3 or 4.
- Intermediaries must determine both the reasonable cost for a service furnished by a provider and the FS amount that would be payable for the service. They then apply the appropriate percentage to each such amount to derive a blended-rate payment amount applicable to the service. The cost report is used for the calculation. The reasonable cost part of the rate is provider specific.

A. Special Instructions for Transition (Intermediaries and Carriers)

CMS will provide each contractor with two files: a national ZIP Code file and a national Ambulance FS file.

The national ZIP5 Code file is a file of 5-digit USPS ZIP Codes that will map each ZIP Code to the appropriate FS locality. Every 2 months, CMS obtains an updated listing of ZIP Codes from the USPS. On the basis of the updated USPS file, CMS updates the Medicare ZIP Code file and makes it available to contractors.

The following is a record layout of the ZIP5 file effective October 1, 2007:

ZIP5 CODE to LOCALITY RECORD LAYOUT

Field Name	Position	Format	COBOL Description
State	1-2	X(02)	Alpha State Code
ZIP Code	3-7	X(05)	Postal ZIP Code
Carrier	8-12	X(05)	Medicare Part B Carrier Number
Pricing Locality	13-14	X(02)	Pricing Locality
Rural Indicator	15	X(01)	Blank = urban, R=rural, B=super rural
Bene. Lab CB Locality	16-17	X(02)	Lab competitive bid locality; Z1= CBA1 Z2= CBA2 Z9= Not a demonstration locality
Filler	18-20	X(03)	
Plus Four Flag	21	X(01)	0 = no +4 extension 1 = +4 extension
Filler	22-75	X(54)	
Year/Quarter	76-80	X(05)	YYYYQ

NOTE: Effective October 1, 2007, claims for ambulance services will continue to be submitted and priced using 5-digit ZIP Codes. Contractors will not need to make use of the ZIP9 file for ambulance claims.

Beginning in 2009, contractors shall maintain separate ZIP Code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP Code file based on the date of service submitted on the claim.

A ZIP Code located in a rural area will be identified with either a letter “R” or a letter “B.” 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.

A “B” designation indicates that the ZIP Code is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. Effective for claims with dates of service between July 1, 2004 and December 31, 2009, contractors must apply a bonus amount to be determined by CMS to the base rate portion of the payment under the FS for ground ambulance services with a POP “B” ZIP Code. This amount is in addition to the rural bonus amount applied to ground mileage for ground transports originating in a rural POP ZIP Code.

Each calendar quarter beginning October 2007, CMS will upload updated ZIP5 and ZIP9 ZIP Code files to the Direct Connect (formerly the Network Data Mover). Contractors shall make use of the ZIP5 file for ambulance claims and the ZIP9 file as appropriate per Pub. 100-04, Chapter 1, Section 10.1.1.1 and the additional information found in Transmittal 1193, Change Request 5208. The updated files will be available for downloading November 15th for the January 1 release, February 15th for the April 1 release, May 15th for the July 1 release, and August 15th for the October 1 release.

Contractors are responsible for retrieving the ZIP Code files upon notification and must implement the following procedure for retrieving the files:

1. Upon quarterly Change Requests, the availability of updated ZIP Code files, go to the Direct Connect and search for the files. Confirm that the release number (last 5 digits) corresponds to the upcoming calendar quarter. If the release number (last 5 digits) does not correspond to the upcoming calendar quarter, notify CMS.
2. After confirming that the ZIP Code files on the Direct Connect corresponds to the next calendar quarter, download the files and incorporate the files into your testing regime for the upcoming model release.

The names of the files will be in the following format:

MU00.AAA2390.ZIP5.LOCALITY.Vyyyyr and MU00.AAA2390.ZIP9.LOCALITY.Vyyyyr where “yyyy” equals the calendar year and “r” equals the release number with January =1, April =2, July =3, and October =4. So, for example, the names of the file updates for October 2007 are MU00.AAA2390.ZIP5.LOCALITY.V20074 and MU00.AAA2390.ZIP9.LOCALITY.V20074. The release number for this file is 20074, release 4 for the year 2007.

When the updated files are loaded to the Direct Connect, they will overlay the previous ZIP Code files.

NOTE: Even the most recently updated ZIP Code files will not contain ZIP Codes established by the USPS after CMS compiles the files. Therefore, for ZIP Codes reported on claims that are not on the most recent ZIP Code files, follow the instructions for new ZIP Codes in [§20.1.5](#).

CMS will also provide contractors with a national Ambulance FS file that will contain payment amounts for the applicable HCPCS codes. The file will include FS payment amounts by locality for all FS localities. The FS file will be available via the CMS Mainframe Telecommunications System. Contractors are responsible for retrieving this file when it becomes available. The full FS amount will be included in this file. CMS will notify contractors of updates to the FS 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.

The addresses for the Fee Schedule Files are as follows:

<u>Calendar Year</u>	<u>File Name</u>
2002	MU00.AAA2390.AMBFS.FINAL.V11
2003	MU00.AAA2390.AMBFS.FINAL.V21
2004	
Jan. 1 – Jun. 30	MU00.AAA2390.AFBFS.FINAL.V32
Jul. 1 – Dec. 31	MU00.AAA2390.AMBFS.FINAL.V33

The following is a record layout of the Ambulance Fee Schedule file:

AMBULANCE FEE SCHEDULE FILE RECORD DESCRIPTION

Field Name	Position	Format	Description
HCPCS	1-5	X(05)	Healthcare Common Procedure Coding System
Carrier Number	6-10	X(05)	
Locality Code	11-12	X(02)	
Base RVU	13-18	s9(4)v99	Relative Value Unit
Non-Facility PE GPCI	19-22	s9v9(3)	Geographic Adjustment Factor
Conversion Factor	23-27	s9(3)v99	Conversion Factor
Urban Mileage/Base Rate	28-34	s9(5)v99	Urban Payment Rate or Mileage Rate (determined by HCPCS)

Field Name	Position	Format	Description
Rural Mileage/Base Rate	35-41	s9(5)v99	Rural Payment Rate or Mileage Rate (determined by HCPCS)
Current Year	42-45	9(04)	YYYY
Current Quarter	46	9(01)	Calendar Quarter – value 1-4
Effective Date*	47-54	9(8)	Effective date of the fee schedule file (MMDDYYYY)
Filler	55-80	X(26)	Future use

*Beginning on July 1, 2004, CMS will add an effective date field to the Ambulance Fee Schedule File in the filler area of the file.

B. Special Carrier Instructions for Transition

As discussed in the previous section, CMS will provide contractors with two files: a ZIP Code file and a national Ambulance FS file. Each carrier must program a link between the ZIP Code file to determine the locality and the FS file to obtain the FS amount.

Carriers pay the lower of the submitted charge or the blended amount determined under the FS transition blending methodology. The specific blending percentages are determined by the date of service on the claim.

For implementing the transition to the FS, the reasonable charge for each supplier is the reasonable charge for 2000 (e.g., the lowest of the customary charge, the prevailing charge, or the IIC previously determined for 2000) adjusted by the ambulance inflation factor, as published by CMS, for each subsequent year ending with the last year of the transition period.

Carriers must send a reasonable charge file to the Railroad Retirement Board, the 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, the carriers send the same reasonable charge data that was developed for the base year (CY 2000) and updated by the AIF for the current year.

Claims are processed using the new HCPCS codes created for the ambulance FS. Carriers must crosswalk HCPCS codes to determine the reasonable charge amount attributable to the new HCPCS codes. If a carrier currently uses local codes, the carrier must establish their own supplemental crosswalk with respect to any such local codes. If a supplier bills a new HCPCS

code for which there is insufficient actual charge data, carriers follow the instructions for gap filling in the Medicare Claims Processing Manual, Chapter 23, “Fee Schedule Administration and Coding Requirements.”

For each ambulance claim, the carrier accesses the ZIP Code file provided by CMS to determine the appropriate locality code for the FS. Only the locality code from the FS should be entered into the claim record in the appropriate field for locality code. The CWF edit for locality code will be bypassed for specialty 59 during the transition period. CWF locality codes are required only for items and services payable by reasonable charge.

To establish a supplier specific reasonable charge for the new HCPCS mileage code A0425, carriers develop an average, e.g., a simple average, not a weighted average, from the supplier specific reasonable charges of the old mileage codes A0380 and A0390. The average amount is used as the reasonable charge for 2001 and updated by the Ambulance Inflation Factor.

If a supplier has established a customary charge for only ALS mileage or only BLS mileage, then that customary charge, subject to the inflation indexed charge (IIC) rules, is used to establish the supplier-specific customary charge amount for the reasonable charge portion of the blended payment for A0425 during the transition period. However, the program’s payment allowance for the reasonable charge portion of the blended payment for A0425 is based on the lower of the supplier’s customary charge (subject to the IIC rules), the prevailing charge, or the prevailing IIC. Therefore, the payment allowance under the reasonable charge portion of the blended payment for A0425 during the transition period will not exceed the prevailing charge or the prevailing IIC that includes both BLS mileage and ALS mileage charge data for the locality in which the charge data was accumulated. The program’s payment allowance for A0425 is then based on the lower of the blended rate and the actual charge on the claim.

Methods 3 and 4 HCPCS codes for items and supplies, J-codes, and codes for EKG testing, are valid until the transition to the FS is completed. Payment for such Method 3 and 4 HCPCS codes (which is available only to a current Method 3 or Method 4 biller at the time the FS was implemented) is based on the reasonable charge for such items and services multiplied by the appropriate transitional blending percentage. The reasonable charge for these HCPCS codes for each year of the transition is determined in the same manner as described above for ambulance services.

C. Carrier/Intermediary Determination of Fee Schedule Amounts

The FS amount is determined by the FS locality, based on the POP of the ZIP Code. Use the ZIP Code of the POP to electronically crosswalk to the appropriate FS amount. All ZIP Codes on the ZIP Code file are urban unless identified as rural by the letter “R” or the letter “B.” Carriers and intermediaries determine the FS amount as follows:

- If an urban ZIP Code is reported with a ground or air HCPCS code, the carriers/intermediaries determine the amount for the service by using the FS amount for the urban base rate. To determine the amount for mileage, multiply the number of reported miles by the urban mileage rate.

- If a rural ZIP Code is reported with a ground HCPCS code, the carrier/intermediary determines the amount for the service by using the FS amount for the urban base rate. To determine the amount for mileage, carriers/intermediaries must use the following formula:
 - For services furnished before July 1, 2004, for rural miles 1-17, the rate equals 1.5 times the urban ground mileage rate per mile. Therefore, multiply 1.5 times the urban mileage rate amount on the FS to derive the appropriate FS rate per mile;
 - For services furnished on or after July 1, 2004, for rural miles 1-17, the rate equals 1.5 times the rural ground mileage rate per mile. Therefore, multiply 1.5 times the rural mileage rate amount on the FS to derive the appropriate FS rate per mile;
 - For services furnished before January 1, 2004, for rural miles 18-50 the rate equals 1.25 times the urban ground mileage rate per mile. Therefore, multiply 1.25 times the urban mileage rate amount on the FS to derive the appropriate FS rate per mile. For all ground miles greater than 50 the FS rate equals the urban mileage rate per mile;
 - For services furnished during the period January 1, 2004 through June 30, 2004, for all ground miles greater than 17, the FS rate equals the urban mileage rate per mile; and
 - For services furnished during the period July 1, 2004 through December 31, 2008, for all ground miles greater than 50 (i.e., miles 51+), the FS rate equals 1.25 times the applicable mileage rate (urban or rural). Therefore, multiply 1.25 times the urban or rural, as appropriate, mileage rate amount on the FS to derive the appropriate FS rate per mile.
- If a rural ZIP Code is reported with an air HCPCS code, the carrier/intermediary determines the FS amount for the service by using the FS amount for rural air base rate. To determine the amount allowable for the mileage, multiply the number of loaded miles by the rural air mileage rate.

D. Summary of Claims Adjudication Under the Transition

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

- The supplier's 2002 reasonable charge for each HCPCS code for each reasonable charge locality is established by adjusting the reasonable charge for 2000 by the 2001 and 2002 ambulance inflation factors. Refer to the chart in the beginning of this section for additional years;

- The carrier must 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. If practical, carriers may convert all suppliers to one billing method. By the full implementation of the FS, all suppliers will bill using the former method 2 for all services. During the transition period, each supplier must select and bill only one method in a carrier's jurisdiction. Providers billing intermediaries use only Method 2;
- For each ambulance claim, the carrier accesses the ZIP Code file provided by CMS to determine both the appropriate locality code for the FS and the rural adjustment indicator, if any;
- 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 FS file;
- If the HCPCS code is a ground service with a rural ZIP Code (as indicated in the ZIP Code file), then the carrier multiplies the number of miles reported (not to exceed 17 miles) by the urban mileage rate specified in the FS file, then this is multiplied by 1.5. For services furnished before January 1, 2004, for any mileage between 18 and 50 the carrier multiplies the number of miles reported (not to exceed 50 miles) by the urban mileage rate specified in the FS file, then this is multiplied by 1.25; any miles in excess of 50 are multiplied by the urban rate. For services furnished during the period January 1, 2004 through June 30, 2004, any miles in excess of 17 are multiplied by the urban rate.
- For services furnished during the period July 1, 2004 through December 31, 2008, the carrier multiplies the number of miles reported that exceed 50 miles (i.e., mile 51 and greater) for both urban and rural ZIP Codes by the applicable mileage rate specified in the FS file (urban or rural), then this is multiplied by 1.25.
- For services furnished during the period January 1, 2004 through June 30, 2004, any miles reported in excess of 17 miles are multiplied by the urban rate; For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).
- If the HCPCS code is an air service with a rural ZIP Code, then the carrier uses the rural service amount and the rural mileage amount;
- The carrier must then add the appropriate transitional blending percentage of the FS amount for the service and the appropriate transitional blending percentage of the reasonable charge 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 the appropriate transitional blending percentage of the FS amount for the mileage and the appropriate transitional blending percentage of the reasonable charge 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 submits a charge for an allowed separately billable item or service as described in the beginning of this section, [§20.1.6](#), the carrier determines the reasonable charge for that year for the reported HCPCS code for the item and multiplies that amount by the appropriate transitional blending percentage. The carrier then compares that amount (because there is no blended FS 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.

NOTE: All transition years are calculated according to the blending percentages described in the beginning of this section, [§20.1.6](#).

20.2 - Determining the Reasonable Charge Base Rate Allowance for Ambulance Services

(Rev. 1, 10-01-03)

B3-5116.1

NOTE: Procedures in [§20.2](#) are being phased out, but the rules apply to the reasonable charge reimbursement methodology. For reasonable charge payments during transition, refer to [§20.1.6](#).

Carriers must develop separate base rates for emergency and nonemergency basic life support (BLS) ambulance and for emergency and nonemergency advanced life support (ALS) ambulance.

The reasonable charge must be established to include the components of each of the methods identified in [§10.2](#) above (e.g., reasonable charge for Method 1 includes services, supplies, and mileage).

A. Both BLS and ALS Ambulance Services Available (Applies to Claims With Dates of Service Prior to 4/1/02)

When there are both BLS and ALS ambulances furnishing services in a locality, carriers establish separate customary and prevailing base rate screens for each type of ambulance in accordance with the usual reasonable charge methodology.

B. Inconsistent Billing Methods for Ambulance Services (Applies to Claims with Dates of Service Prior to 4/1/02)

When the billing practices of suppliers of ambulance services are not consistent, e.g., some suppliers bill an all-inclusive base rate while others bill a base rate plus separate charges for covered specialized services, carriers develop and use different base rate prevailing charges for each type of billing arrangement:

1. The carrier uses only the all-inclusive charges for covered Part B services in calculating the customary and prevailing base rate screens for ambulance suppliers who bill all-inclusive charges; and
2. The carrier merges the data on base rate charges for ambulance suppliers not included in paragraph 1 to establish a base rate prevailing charge screen for such ambulance services. Separate additional charges may be allowed for a specialized ambulance service as indicated in §20.3 below, if the service is covered under Part B, so long as the total reasonable charge allowed for the ambulance service generally does not exceed the all-inclusive prevailing base rate for ambulance services (where there is one).

If there are only ambulance suppliers with separate additional charges for specific covered services in the locality (e.g., no all-inclusive ambulance billers), the ambulance suppliers' charges would be used to establish the reasonable charge screens.

20.3 - Effect of Separate Charges for Covered Specialized ALS Services on Reasonable Charges for Ambulance Services

(Rev. 1, 10-01-03)

B3-5116.2

This section applies to claims with dates of service prior to April 1, 2002, and the reasonable charge portion of the payment during the fee schedule transition.

Where separate charges are billed for the specific covered ALS services, reasonable charge screens for each such service should be constructed using the regular reasonable charge methodology. When a claim is filed for any one or a combination of such covered services, the maximum allowable charge for the total ambulance service must take into consideration the supplier's base rate reasonable charge (see §20.2.B) plus the reasonable charge for the specific specialized service(s).

For example, if an ambulance supplier submits a separate additional charge for covered EKG monitoring, the maximum reasonable charge for the ambulance service would be the lowest of:

1. The supplier's actual base rate and specialized service charge;
2. The supplier's customary base rate and customary specialized service charge; or
3. The prevailing base rate charge in the locality for basic ambulance services and the prevailing charge for the specialized service.

An increase in the reasonable charge for the ambulance service because of separately itemized specialized services should be allowed **only** where such a service is determined to be reasonable and necessary.

20.4 - Payment for Mileage Charges

(Rev. 1, 10-01-03)

B3-5116.3, PM AB-00-131

In service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on customary and prevailing mileage charges may be allowed. Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to his/her arrival at destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes his basic charge for ambulance services and his rate for loaded mileage. Suppliers should be notified that separate charges for unloaded mileage will be denied.

Instructions on billing mileage are found in §30.1.

20.5 - Air Ambulance

(Rev. 1, 10-01-03)

PMs AB-01-165, AB-02-036, and AB-02-131; B3-5116.5, B3-5205 partial

Refer to the Medicare Benefit Policy Manual, Chapter 10, "Ambulance," §10.4, for additional information on the coverage of air ambulance services. Under certain circumstances, transportation by airplane or helicopter may qualify as covered ambulance services. If the conditions of coverage are met, payment may be made for the air ambulance services.

Prior to the implementation of the fee schedule, in areas where the charging practices for air ambulances do not differ materially from those used by land ambulances, carriers are to apply the normal reasonable charge amount for this class of service.

In those areas in which the suppliers of air ambulance services have unique charging practices, carriers must use discretion in properly applying reasonable charge criteria based on first-hand knowledge of such charging methods. The limited number of air ambulance suppliers in many areas may necessitate the expansion of the definition of "locality" for prevailing charge computations to include customary charges in other localities, even beyond the service area. When faced with the situation of a lone supplier of air ambulance service, carriers should apply the same guidelines that are used for determining the reasonable charge for a rare or unusual procedure. In such situations, in order to make the reasonable charge determination, the carrier:

- a. Obtains data, if possible, on the charges made for the unusual or rare procedure in other areas similar to the locality in which the service was rendered; or

b. Consults with the local medical society regarding the appropriate charge to be made for this procedure.

Also, should it be determined in a particular case that the use of a land ambulance would have sufficed in lieu of air ambulance service, the reasonable charge should be limited to the amount which would have been payable for a land ambulance if this amount is less than the air ambulance charge.

On or after the implementation of the fee schedule, air ambulance services are paid at different rates according to two air ambulance categories:

- **AIR** ambulance service, conventional air services, transport, one way, **fixed wing** (FW) (HCPCS code A0430)
- **AIR** ambulance service, conventional air services, transport, one way, **rotary wing** (RW) (HCPCS code A0431)

Covered air ambulance mileage services are paid when the appropriate HCPCS code is reported on the claim:

- HCPCS code A0435 identifies FIXED WING AIR MILEAGE
- HCPCS code A0436 identifies ROTARY WING AIR MILEAGE

Air mileage must be reported in whole numbers of loaded statute miles flown. Contractors must ensure that the appropriate air transport code is used with the appropriate mileage code.

Air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician's office, or a patient's home may not be paid air ambulance. The destination is identified by modifiers.

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing. Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions;
- Hazardous weather; or
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

Chapter 6 of the Medicare Program Integrity Manual contains instructions for Medical Review of Air Ambulance Services.

20.5.1 - Air Ambulance for Deceased Beneficiary

(Rev. 437, Issued: 01-21-05, Effective: 01-01-05, Implementation: 02-22-05)

The policy in this section is effective for carriers March 7, 2002, and for intermediaries July 1, 2002.

Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, e.g., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed. For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

Also no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

Providers and suppliers must use the modifier QL (Patient pronounced dead after ambulance called) to indicate the circumstance when an air ambulance takes off to pick up a beneficiary but the beneficiary is pronounced dead before the pickup can be made.

The provider/supplier must submit documentation with the claim sufficient to show that:

- a. The air ambulance was dispatched to pick up a Medicare beneficiary;
- b. The aircraft actually took off to make the pickup;
- c. The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport;
- d. The pronouncement of death was made by an individual authorized by State law to make such pronouncements; and
- e. The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

Contractors must allow the appropriate air base rate (fixed wing or rotary wing, as applicable) for a claim for an air ambulance service for deceased beneficiaries but not allow mileage or make a rural adjustment. During the fee schedule transition, contractors must allow an amount based on a blended rate.

For intermediaries, this policy applies to the following types of bills: 12X, 13X, 22X, 23X, 83X, and 85X. Refer to §30 below for additional billing guidelines.

20.6 - Update Charges

(Rev. 1, 10-01-03)

AB-01-22, AB-00-87, AB-01-185

Update factors described in this section apply to the reasonable charge portion of the ambulance payment. During the fee schedule transition, the examples below describe how the updates are applied to the reasonable charge portion of the payment.

In general, for 2001, the reasonable charge is the reasonable charge limit for 2000 (e.g., the lowest of the 2000 prevailing charge, customary charge, or IIC) multiplied by the reasonable charge ambulance inflation factor for 2001. 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 and so on through the transition period.

EXAMPLE A: 1/01/01 - 6/30/01

For services furnished during the period January 1, 2001, through June 30, 2001, the 2001 IIC update factor for ambulance services (also known as the ambulance inflation factor) paid under reasonable charges **remains at 2.7 percent**. Therefore, the carriers calculate the 2001 reasonable charge screen amount for ambulance services furnished during this period by increasing the 2000 reasonable charge screen amount by 2.7 percent. Intermediaries limit the reasonable cost per trip reimbursement for ambulance services furnished during this period to no more than the reasonable cost per trip limit for services furnished in fiscal year 2000 updated by 2.7 percent.

EXAMPLE B: 7/1/01 - 12/31/01

For services furnished during the period July 1, 2001, through December 31, 2001, the reasonable charge update factor applicable to ambulance services is **4.7 percent**. Therefore, carriers calculate the 2001 reasonable charge screen amount for ambulance services furnished during this period by increasing the 2000 reasonable charge screen amount by 4.7 percent. Intermediaries limit the reasonable cost per trip reimbursement for ambulance services furnished during this period to no more than the reasonable cost per trip limit for services furnished in fiscal year 2000 increased by 4.7 percent.

(NOTE: This 4.7 percent increase is applied to the 2000 reasonable cost limit amount, **not** to the 2001 reasonable cost limit amount.)

20.6.1 - Ambulance Inflation Factor (AIF)

(Rev. 1375, Issued: 11-09-07, Effective: 01-01-08, Implementation: 01-07-08)

Section 1834(l)(3)(B) of the Social Security Act (the Act) provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2008 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the AIF.

The national fee schedule for ambulance services has been phased in over a 5-year transition period beginning April 1, 2002. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) also established that for ambulance services furnished during the period July 1, 2004, through December 31, 2009, the ground ambulance base rate is subject to a floor amount, which is determined by establishing nine fee schedules based on each of the nine census divisions, and using the same methodology as was used to establish the national fee schedule. If the regional fee schedule methodology for a given census division results in an amount that is lower than the national ground base rate, then it is not used, and the national fee schedule amount applies for all providers and suppliers in the census division. If the regional fee schedule methodology for a given census division results in an amount that is greater than the national ground base rate, then the fee schedule portion of the base rate for that census division is equal to a blend of the national rate and the regional rate. For CY 2008, this blend would be 20 percent regional ground base rate and 80 percent national ground base rate. Prior to January 1, 2006, during the transition period, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional (if it applied)) and to the reasonable cost or charge portion of the blended payment amount separately, respectively, for each ambulance provider or supplier. Then, these two amounts were added together to determine the total payment amount for each provider or supplier. As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national ambulance fee schedule. As of January 1, 2008, the total payment amount for ground ambulance providers and suppliers will be based on either 100 percent of the national ambulance fee schedule or 80 percent of the national ambulance fee schedule, and 20 percent of the regional ambulance fee schedule, whichever is greater.

The AIF for calendar year 2008 is **2.7 percent**. Part B coinsurance and deductible requirements apply. The 2008 ambulance fee schedule file is available upon publication of the Change Request (CR). It may be retrieved at any time and will reside indefinitely for your access. It may be updated with each quarterly Common Working File (CWF) update. The address for the file is as follows:

[MU00.@AAA2390.AMBFS.FINAL.V71](#)

Following is a chart tracking the history of the AIF:

<u>AIF</u>	<u>CY</u>
1.1	2003
2.1	2004
3.3	2005
2.5	2006

4.3 2007

2.7 2008

20.7 - Joint Responses

(Rev. 1, 10-01-03)

AB-02-131

A. BLS/ALS Joint Responses

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, Paramedic Intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by **their intermediary or carrier upon request**. Contractors must refer any issues that cannot be resolved to the regional office.

There must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service prior to submitting the Medicare claim.

Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

B. Ground to Air Ambulance Transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided and mileage from the point of pickup to the point of transfer to the air ambulance.

20.8 - Other Unusual Circumstances

(Rev. 1, 10-01-03)

B3-5116.6

As with any reasonable charge determination, amounts above the reasonable charge may be allowed when unusual circumstances are documented. Carriers are expected to make such determinations, with medical staff assistance as needed and on a case by case basis, in deciding whether the services actually furnished exceed the range of services ordinarily provided. Such situations include but are not limited to: Night services, use of extra attendants to handle disturbed patients, and where the facts indicate that a situation existed above and beyond normal ambulance transportation which justified additional charges.

These services may only be paid through the transition (using the reasonable charge percentages with **NO** ambulance fee schedule percentage) **AND** may only be paid by carriers who were paying for these services prior to April 1, 2002.

When the fee schedule is fully implemented, payment will be based solely on the calculated fee schedule amount.

20.9 - Single Ambulance Where Multiple Patients Are on Board

(Rev. 1, 10-01-03)

PMs B-02-060, AB-01-185, A-02-108; CMS Q&As, B3-5215.2

The payment policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance is as follows:

1. When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport. (The allowed charge for a single beneficiary transport is the lower of (a) the submitted charge or (b) the fee schedule amount for the service, which during the fee schedule transition period is a blended amount.) The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

NOTE: This policy applies to both ground and air transports. For purposes of this section, the term “ground transport” includes transports by water ambulance.

2. If two patients are transported at the same time in one ambulance to the same destination, the adjusted payment allowance for each Medicare beneficiary is equal to 75 percent of the single-patient allowed amount applicable to the level of service furnished a beneficiary plus 50 percent of the total mileage payment allowance for the entire trip.

3. If three or more patients are transported at the same time in one ambulance to the same destination, the adjusted payment for each Medicare beneficiary is equal to 60 percent of the single-patient allowed amount applicable to the level of service furnished that beneficiary plus a proportional mileage allowed amount, e.g., the total mileage allowed amount divided by the number of all the patients onboard.

The fact that the level of medically necessary service among the patients may be different is not relevant to this payment policy. The percentage is applied to the allowed amount applicable to the level of service that is medically necessary for each beneficiary.

4. If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency versus nonemergency ground transport.

a. For an emergency ground transport, which includes BLS-E, ALS1-E, ALS2, and SCT, the mileage payment shall be based on the number of miles to the nearest appropriate facility for each patient divided by the number of patients on board when

the vehicle arrives at the facility. This formula applies cumulatively for beneficiaries who are the second or third patient to be delivered. Absent evidence to the contrary, carriers should assume that the sequence of deliveries was predicated on the medical needs of each patient.

b. For a nonemergency ground transport, which includes BLS and ALS1, the mileage payment shall be based on the number of miles from the point of pickup to the nearest appropriate facility for each beneficiary divided by the number of beneficiaries on board at the point of pickup. This formula applies cumulatively for beneficiaries for multiple points of pickup. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pickup to the nearest appropriate facility is not covered. Thus, for nonemergency transports, the extra mileage that may be incurred by having multi-destinations shall not be taken into account.

c. For air transports the policy is the same as for emergency ground transports.

5. If a Medicare beneficiary is furnished medically necessary supplies and the supplier bills supplies separately, then the allowed amount of the supplies is not subject to an apportionment for multiple patients. The allowed amount for supplies should be determined in the same manner as if the beneficiary was the only patient onboard the vehicle.

Carriers must accept and instruct their suppliers to use modifier “GM” to identify a multiple transport. They must require suppliers to submit:

- Documentation to specify the particulars of a multiple transport: The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers for each Medicare beneficiary;
- Charges applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip;
- All associated Medicare claims for that multiple transport within a reasonable number of days of submitting the first claim;

If there is only one Medicare beneficiary in the multiple patient transport, contractors must process the claims using the necessary information from the supplier’s documentation.

If more than one Medicare beneficiary is transported in a multiple patient transport, then the contractor must associate all ambulance claims for Medicare beneficiaries for the one transport.

The contractor must process the claims and apply the correct percentages to the allowed amount applicable to the level of service furnished and mileage.

When two patients are transported, for each beneficiary:

- The contractor allows 75 percent of the allowed amount for a single-person transport (excluding separately billable mileage);

- For mileage to a single destination, the contractor allows half of the total mileage;
- For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for the first leg is the amount for the mileage divided by two. The allowed amount for the second leg is the full mileage. Thus, payment on behalf of a beneficiary whose transport is to the first nearest appropriate facility is based on half the mileage amount to that facility; whereas, payment on behalf of the second beneficiary, whose transport was to the next nearest appropriate facility, would be based on half of the mileage to the first facility plus all of the mileage from the first facility to the second facility.

For mileage for nonemergency ground transports, carriers may allow only the mileage from the point of pickup to the nearest appropriate facility and then divide that amount by the number of beneficiaries loaded on board at the point of pickup. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pickup to the nearest appropriate facility is not covered.

When three or more patients are transported, for each beneficiary:

- The carrier allows 60 percent of the allowed amount for a single-person transport (excluding separately billable mileage);
- For mileage to a single destination, the carrier allows a pro rata share of the total mileage;
- For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for each leg of the transport is a pro rata share of the total mileage based on the number of patients on board upon arrival at each destination.

For mileage for nonemergency ground transports, the allowed amount for each beneficiary is based on the mileage to the nearest appropriate facility divided by the number of beneficiaries loaded on board at the point of pickup (including any intermediate points of pickup). Carriers do not take into account any mileage other than the mileage that would be incurred from transporting each beneficiary directly from the point of pickup to the nearest appropriate facility.

Additionally for intermediaries for claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. However, due to systems changes, providers should not submit these claims until on or after April 1, 2003. Claims with value code 32 submitted before April 1, 2003, will be returned to the provider. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter. Providers may not report additional ambulance services on a claim that contains a multiple patient ambulance transport, even if the point of pickup ZIP Code is the same. A separate claim must be submitted for additional ambulance services.

Contractors must use the appropriate message to indicate that there is a reduction. Carriers use message codes M16 and N45.

Medicare Part B coinsurance, deductible, and mandatory assignment apply to these prorated payments.

20.10 - Waiting Time Charges Made by Ambulance Companies

(Rev. 1, 10-01-03)

B3-5215, B3-5024 partial

Waiting time charges are charges an ambulance service company makes for time spent while waiting for the patient. Ambulance companies, in arriving at their charge rates, usually consider that the total time involved in picking up a patient and transporting him to his destination involves some waiting time. This waiting time is not a separate identifiable part of the charge rate for covered ambulance service and, therefore, not reimbursable as a separate charge unless the waiting time is extraordinarily long and constitutes unusual circumstances. The reasonableness of the additional amount charged in any given instance must be determined based on knowledge of all the pertinent facts including:

- a. The customary additional charge, under the circumstances, of the physician or other person rendering the service;
- b. The prevailing charging practices under such circumstances of physicians and other persons in the locality; and
- c. The additional time spent or expenses incurred by the physician or other person rendering the service.

When carriers receive a claim on which the submitted charge substantially exceeds the normal reasonable charge amount for waiting time, they must send it to the utilization review unit for its review. Once the review unit has made a determination to pay an amount higher than the customary or prevailing charge, documentation to support the reason for this determination **must** accompany the claim.

Carriers must exercise discretion in processing claims involving waiting time so that reimbursement is not made for unwarranted waiting time. Such caution is necessary since determining what constitutes unusual circumstances is a judgmental decision. To facilitate that determination and to avoid unnecessary development and delays, carriers instruct the suppliers of ambulance services to include on their bills an explanation of any unusual circumstances that had a bearing on their charges.

These services may only be paid through the transition (using the reasonable charge percentages with **NO** ambulance fee schedule percentage) **AND** may only be paid by carriers who were paying for these services prior to April 1, 2002.

When the fee schedule is fully implemented, payment will be based solely on the calculated fee schedule amount.

20.10.1 - Requirements for Approval of Waiting Time

(Rev. 1, 10-01-03)

B3-5215.1

If the carrier established that the waiting time constitutes unusual circumstances sufficient to warrant coverage, payment may be made if certain conditions are satisfied. However, the maximum allowable combined charges for the ambulance service and waiting time may not exceed the amount that the total charges would have been if the ambulance had returned to its base of operations and then returned to pick up the patient and transport him. These conditions are:

1. The ambulance company makes a separate charge to all patients, both Medicare and non-Medicare, for unusual waiting time;
2. It is the general practice of ambulance companies in the locality to make an extra charge for unusual waiting time; and
3. The claim is completely documented as to why the ambulance was required to wait and the exact time involved. The ambulance company should ordinarily obtain this documentation from the physician or hospital personnel responsible for admitting or discharging patients.

However, if this is not possible, the documentation may be a statement from the ambulance company based on a record containing all pertinent facts necessary to support the claim. The ambulance company could establish the necessary record by instructing its crews to ascertain from the physician or responsible hospital personnel the reason for the wait at the time it occurs. The reason could be entered on the ambulance log over the signature of the physician or other informant.

20.11 – Documentation Requirements

(Rev. 1, 10-01-03)

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

Pub 100-1, Chapter 4, "Physician Certifications and Recertification of Services," contains specific information on supplier requirements for ambulance certification.

Chapter 6, "Intermediary MR Guidelines for Specific Services," of the Medicare Program Integrity Manual contains information on medical review instructions of ambulance services.

30 - General Billing Guidelines - Intermediaries and Carriers

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Ambulance suppliers may bill the carrier on Form CMS-1500, Health Insurance Claim Form; the NSF EDI data set; or the ANSI X12N 837 data set.

Hospitals and SNFs that bill the intermediary use Form CMS-1450 or the ANSI X12N 837.

A. Modifiers Specific to Ambulance

Two of the following modifiers are required for each base line item to report the origin and the destination:

- D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
- E = Residential, domiciliary, custodial facility (other than 1819 facility);
- G = Hospital based ESRD facility;
- H = Hospital;
- I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
- J = Freestanding ESRD facility;
- N = Skilled nursing facility;
- P = Physician’s office;
- R = Residence;
- S = Scene of accident or acute event;
- X = Intermediate stop at physician’s office on way to hospital (destination code only)
- R = Residence;
- S = Scene of accident or acute event;
- X = Intermediate stop at physician’s office on way to hospital (destination code only)

B. HCPCS Codes

The following codes and definitions are effective for billing ambulance services on or after January 1, 2001.

AMBULANCE HCPCS CODES CROSSWALK AND DEFINITIONS

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
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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)
Q3020	Ambulance service, advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0304 (Method 1)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0306 (Method 1)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0308 (Method 1)
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)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0324 (Method 2)

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0326 (Method 2)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0328 (Method 2)
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)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed	A0344 (Method 3)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0346 (Method 3)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed	A0348 (Method 3)
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)

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
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)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0364 (Method 4)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0366 (Method 4)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0368 (Method 4)
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

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
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
A0800 (Effective 1/5/2004)	Ambulance transport provided between the hours of 7 pm and 7 am	Local Carrier Code
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

NOTE: PI, ALS2, SCT, FW, and RW assume an emergency condition and do not require an emergency designator.

Refer to the Medicare Benefit Policy Manual, Chapter 10, §30.1, for the definitions of levels of ambulance services under the fee schedule.

During the transition period, if an ALS vehicle is used for an emergency transport but no ALS level service is furnished, the fee schedule (FS) portion of the blended payment will be based on the emergency BLS level. The amount on the FS for HCPCS code Q3019 is the same fee as BLS-Emergency (BLS-E) FS HCPCS code A0429. The reasonable charge/cost portion of the blended payment will be the ALS emergency rate.

During the transition period, if an ALS vehicle is used for a nonemergency transport but no ALS level service is furnished, the FS portion of the blended payment will be based on the nonemergency BLS level. The amount displayed on the FS for HCPCS code Q3020 is the same fee displayed for BLS nonemergency, FS HCPCS code A0428. The reasonable charge/cost portion of the blended payment will be the ALS nonemergency rate.

Codes Q3019 and Q3020 are relevant for transitional billing purposes only. (There were old codes that existed for these services that can no longer be used for payment purposes).

HCPCS Code A0800 for ambulance night differential charges, effective January 5, 2004, is valid during the transition period only, and may only be billed in those carrier jurisdictions that paid separately for these charges prior to the implementation of the Ambulance Fee Schedule on April 1, 2002. Therefore, carriers that did not allow separate charges for night services must not begin using HCPCS code A0800. Carriers not eligible to use HCPCS code A0800 must deny claims for such services.

30.1 - Carrier Guidelines

(Rev. 1, 10-01-03)

B3-5116

Ambulance providers are paid under one of four billing methods described in §10.2 above. In some areas, there may be two or more ambulance companies billing differently based on the billing method selected, e.g., one may bill on the basis of a base rate plus mileage whereas another may use a rate based on mileage only. Furthermore, one company may have an all-inclusive rate whereas another may bill standard rate plus extra charges based on actual additional services furnished, such as EKG monitoring.

Payment under the fee schedule for ambulance services:

- Includes 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.

Services paid separately under reasonable charge (e.g., ambulance waiting time, disposable supplies, or extra ambulance attendant) will continue to be separately payable under the reasonable charge portion of the transitional blended rate.

30.1.1 - Carrier Coding Requirements for Suppliers

(Rev. 1, 10-01-03)

PM AB-00-88

The implementation of the ambulance fee schedule resulted in the need for HCPCS coding changes, primarily because of the following:

- 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 5-digit ZIP Code);
- Increased payment for rural services; and
- Services and supplies included in base rate.

There is no grace period for old HCPCS codes once their respective new HCPCS codes are effective. Depending on the supplier's billing method certain old HCPCS codes for items and services may continue to be used, including J-codes and codes for EKG testing, during the transition period. See the beginning of [§20.1.6](#) of this chapter.

30.1.2 - Coding Instructions for Form CMS-1500

(Rev. 1, 10-01-03)

PMs AB-00-88, AB-00-118, AB-00-131

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

There will be no grace period to transition the use of the new HCPCS codes. Carriers return as unprocessable any claim submitted with old HCPCS codes for dates of service January 1, 2001, and later (with the exception of HCPCS codes A0380 and A0390 which apply until April 1, 2002 and those HCPCS codes for items and services that suppliers using certain billing methods 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 CMS-1500, billers code the 5-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 ANSI X12N 837 (3051) and (3032) are to report the origin information (e.g., the ZIP Code of the point of pickup) in loop 2310A (Facility Address). NM1 is required. NM101 will have the value "61" (Performed At) and NM102 will have the value "2" (nonperson entity). The remaining fields are not required: N2 (Facility Name) is not required; N3 (Facility Address) is not required. N4 (Facility City, State, ZIP) is required. N401 is used to report the 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. Carriers use message N53 on the remittance advice in conjunction with reason code 16.

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

If the ZIP Code entered on the claim is not in the CMS-supplied ZIP Code File, the carriers 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). ZIP Code information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP Code, the claim can be processed. All such ZIP Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP Code, the claim must be rejected as unprocessable.

Generally, each ambulance trip will require two lines of coding, e.g., 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 less than a mile.

30.1.3 - Coding Instructions for Form CMS-1491 (Rev. 1144, Issued: 12-29-06, Effective: 04-02-07, Implementation: 04-02-07)

Effective April 2, 2007, Form CMS-1941 will no longer be a valid format for submitting claims. Suppliers who wish to submit a paper claim must use Form CMS-1500.

For claims with Dates of Receipt prior to April 2, 2007:

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

The service HCPCS code is entered into item 22 as well as any information necessary to describe the illness or injury.

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

There is no grace period to transition the use of the new HCPCS codes. Carriers 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 transition years 1, 2, 3, and 4).

Generally, a claim for an ambulance service will require two entries, e.g., 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.

The mileage HCPCS code is entered into item 14 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 less than a mile

NOTE: To bill mileage, providers and suppliers continue to use codes A0380 and A0390 for dates of service January 1, 2001 through March 31, 2002.

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. Carriers 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, carriers 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, carriers validate only the first 5 digits. If the ZIP Code entered into item 12 does not correspond to a USPS either 5- or 9-digit format, carriers 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). ZIP Code information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP Code information may be consulted. If this process validates the ZIP Code, the claim may be processed. All such ZIP

Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP Code, the claim must be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

30.1.4 – CWF Editing of Ambulance Claims for Inpatients

(Rev. 668, Issued: 09-02-05; Effective: Ambulance claims received on or after January 3, 2006, and 4 years after initial determination for adjustments; Implementation: 01-03-06)

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay. CWF performs reject edits to incoming claims from suppliers of ambulance services.

Upon receipt of a hospital inpatient claim at the CWF, CWF searches paid claim history and compares the period between the hospital inpatient admission and discharge dates to the line item service date on an ambulance claim billed by a supplier. The CWF will generate an unsolicited response when the line item service date falls within the admission and discharge dates of the hospital inpatient claim.

Upon receipt of an unsolicited response, the carrier will adjust the ambulance claim and recoup the payment.

Ambulance services with a date of service that is the same as the admission or discharge date on an inpatient claim are separately payable and not subject to the bundling rules.

30.2 - Intermediary Guidelines

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

For SNF Part A, the cost of transportation to receive most services included in the RUG rate is included in the cost for the service. This includes transportation in an ambulance. Payment for the SNF claim is based on the RUGs, and recalibration for future years takes into account the cost of transportation to receive the ancillary services.

If the services are excluded from the SNF PPS rate, the ambulance service may be billed separately as can the excluded service.

Refer to section 10.5, of chapter 3, of the Medicare Claims Processing Manual, for additional information on hospital inpatient bundling of ambulance services.

In general, the intermediary processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill intermediaries using only Method 2.

The provider must furnish the following data in accordance with intermediary instructions. The intermediary will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;

- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. General

The reasonable cost per trip of ambulance services furnished by a provider of services may not exceed the prior year's reasonable cost per trip updated by the ambulance inflation factor. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997, and September 30, 1998).

Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

The following instructions provide billing procedures implementing the above provisions.

B. Applicable Bill Types

The appropriate type of bill (13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.

C. Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance in the Value Code field. 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 location right justified to the left to the dollar/cents delimiter.

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.

NOTE: Information regarding the claim form locator that corresponds to the Value Code field and a table to crosswalk the CMS-1450 form locator to the 837 transaction is found in Chapter 25.

D. Revenue Code/HCPCS Code Reporting

Providers must report revenue code 054X and, for services **provided before January 1, 2001**, one of the following CMS HCPCS codes for each ambulance trip provided during the billing period:

A0030 (discontinued 12/31/2000);
A0040 (discontinued 12/31/2000);
A0050 (discontinued 12/31/2000);
A0320 (discontinued 12/31/2000);
A0322 (discontinued 12/31/2000);
A0324 (discontinued 12/31/2000);
A0326 (discontinued 12/31/2000);
A0328, (discontinued 12/31/2000); or
A0330 (discontinued 12/31/2000).

In addition, providers report one of A0380 or A0390 for mileage HCPCS codes. No other HCPCS codes are acceptable for reporting ambulance services and mileage.

Providers report one of the following revenue codes:

0540;
0542;
0543;
0545;
0546; or
0548.

Do not report revenue codes 0541, 0544, or 0547.

For claims with **dates of service on or after January 1, 2001**, providers must report revenue code 540 and one of the following HCPCS codes for each ambulance trip provided during the billing period:

A0426;

A0427;

A0428;

A0429;

A0430;

A0431;

A0432;

A0433; or

A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly.

In addition, all providers report one of the following mileage HCPCS codes:

A0380;

A0390;

A0435; or

A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, providers must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

However, in the case where the beneficiary was 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. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Providers report the A0428 (BLS) HCPCS code. Providers

report modifier QL (Patient pronounced dead after ambulance called) in Form Locator (FL) 44 “HCPCS/Rates” instead of the origin and destination modifier. In addition to the QL modifier, providers report modifier QM or QN.

NOTE: Information regarding the claim form locator that corresponds to the HCPCS code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.

E. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of x, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D - Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes;

E - Residential, Domiciliary, Custodial Facility (other than an 1819 facility);

H - Hospital;

I - Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;

J - Nonhospital based dialysis facility;

N - Skilled Nursing Facility (SNF) (1819 facility);

P - Physician’s office (Includes HMO nonhospital facility, clinic, etc.);

R - Residence;

S - Scene of accident or acute event; or

X - (Destination Code Only) intermediate stop at physician’s office enroute to the hospital. (Includes HMO nonhospital facility, clinic, etc.)

In addition, providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM - Ambulance service provided under arrangement by a provider of services; or

QN - Ambulance service furnished directly by a provider of services.

F. Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one

ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in the Service Date field.

NOTE: Information regarding the claim form locator that corresponds to the Service Date and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.

G. Service Units Reporting

For line items reflecting HCPCS code A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001**) or code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**services on and after January 1, 2001**), providers are required to report in Service Units each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, the number of loaded miles must be reported. (See examples below.)

Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, A0435, or A0436, the number of loaded miles must be reported.

H. Total Charges Reporting

For line items reflecting HCPCS code:

A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001**);

OR

HCPCS code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**on or after January 1, 2001**);

Providers are required to report in 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 code A0380, A0390, A0435, or A0436, report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., 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 base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units as a separate line item. For the related charges, providers report \$1.00 in FL48 for noncovered charges. Intermediaries should assign ANSI Group Code OA to the \$1.00 noncovered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

Prior to submitting the claim to CWF, the intermediary will remove the entire revenue code line containing the mileage amount reported in Noncovered Charges to avoid nonacceptance of the claim.

NOTE: Information regarding the claim form locator that corresponds to the Charges fields and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.

EXAMPLES: The following provides examples of how bills for Part B ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by providers. Ambulance services provided under arrangement between the provider and an ambulance company are reported in the same manner except providers report a QM modifier instead of a QN modifier. The following examples are for claims submitted with dates of service on or after January 1, 2001.

EXAMPLE 1: Claim containing only one ambulance trip:

For the hard copy Form CMS-1450, providers report as follows:

Revenue Code	HCPCS/ Modifiers	Date of Service	Units	Total Charges
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2: Claim containing multiple ambulance trips:

For the hard copy Form CMS-1450, providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00
0540	A0330	RH	QN	082901	1 (trip)	400.00
0540	A0390	RH	QN	082901	3 (mileage)	6.00

EXAMPLE 3: Claim containing more than one ambulance trip provided on the same day:

For the hard copy CMS-1450, providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
0540	A0429	RH	QN	090201	1 (trip)	100.00
0540	A0380	RH	QN	090201	2 (mileage)	4.00
0540	A0429	HR	QN	090201	1 (trip)	100.00
0540	A0380	HR	QN	090201	2 (mileage)	4.00

I. Edits

Intermediaries edit to assure proper reporting as follows:

- For claims with dates of service before January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance trip HCPCS codes - A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330; and one of the following mileage HCPCS codes - A0380 or A0390;
- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes – A0435, A0436 or for claims with dates of service before April 1, 2002, A0380, or A0390, or for claims with dates of service on or after April 1, 2002, A0425;
- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;
- The units field is completed for every line item containing revenue code 0540;
- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;
- Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, A0330, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal “1”

For claims with dates of service on or after July 1, 2001, each 1-way ambulance trip, line-item dates of service for the ambulance service, and corresponding mileage are equal.

30.2.1 - Provider/Intermediary Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation

(Rev. 668, Issued: 09-02-05; Effective: Ambulance claims received on or after January 3, 2006, and 4 years after initial determination for adjustments; Implementation: 01-03-06)

PMs AB-00-88, AB-00-118, A3-3660.1, PM A-01-48, SNF 539, HHA 477, HO 433, Cindy Murphy and Barbara Griffen e-mail, PMs AB-00-118, AB-00-131

These instructions are for claims with dates of service on or after April 1, 2002. Instructions contained in §30.2 are applicable for claims with dates of service prior to April 1, 2002.

For SNF Part A, the cost of transportation to receive most services included in the RUG rate is included in the cost for the service. This includes transportation in an ambulance. Payment for the SNF claim is based on the RUGs, and recalibration for future years takes into account the cost of transportation to receive the ancillary services.

If the services are excluded from the SNF PPS rate, the ambulance service may be billed separately as can the excluded service.

Refer to section 10.5, of chapter 3, of the Medicare Claims Processing Manual, for additional information on hospital inpatient bundling of ambulance services.

In general, the intermediary processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill intermediaries using only Method 2.

The provider must furnish the following data in accordance with intermediary instructions. The intermediary will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. Revenue Code Reporting

Providers report ambulance services under revenue code 540 in FL 42 “Revenue Code.”

B. HCPCS Codes Reporting

Providers report the new HCPCS codes established for the ambulance fee schedule. No other HCPCS codes are acceptable for the reporting of ambulance services and mileage. The new HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used. (Not all previous HCPCS codes are applicable to providers since providers have been reporting the all-inclusive rate and mileage codes as described in §30.2.)

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.

These are the same codes required effective for services January 1, 2001.

In addition, providers must report **one** of HCPCS mileage 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 (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported. Providers code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

C. 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".

D. 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.

E. 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 instances where the provider does not incur any cost for mileage, e.g., 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 base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units. For the related charges, providers report \$1.00 in noncovered charges. Intermediaries should assign ANSI Group Code OA to the \$1.00 noncovered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

NOTE: For Method 3 and 4 billers, also report the supplies, etc., separately through the transition period. The appropriate submitted amount for supplies, etc., should be entered for each service.

F. Edits (Intermediary Claims With Dates of Service On or After 4/1/02)

For claims with dates of service on or after April 1, 2002, intermediaries perform the following edits to assure proper reporting:

- Edit to assure each pair of revenue codes 540 have one of the following ambulance HCPCS 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, 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 "1"; and
- Edit to assure on every claim that revenue code 540, a value code of A0 (zero), and a corresponding ZIP Code are reported. If the ZIP Code is not a valid ZIP Code in accordance with the USPS assigned ZIP Codes, intermediaries verify the ZIP Code to determine if the ZIP Code is a coding error on the claim or a new ZIP Code from the USPS not on the CMS supplied ZIP Code File.

G. CWF (Intermediaries)

Intermediaries report the procedure codes in the financial data section (field 65a-65j). They include revenue code, HCPCS code, units, and covered charges in the record. Where more than one HCPCS code procedure is applicable to a single revenue code, the provider reports each HCPCS code and related charge on a separate line, and the intermediary reports this to CWF. Report the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h, "Covered Charges."

H. 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. In addition, the necessary statistics are maintained for the Provider Statistics & Reimbursement Report (PS&R). This ensures that the ambulance fee schedule portion of the blended transition payment is not cost settled at cost settlement time. See the PS&R guidelines for specific information.

30.2.2 - Payment Rules for Intermediaries During Fee Schedule Transition

(Rev. 1, 10-01-03)

PMs AB-00-88, AB-01-165, AB-02-117, AB-01-185

The transition begins April 1, 2002, 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 April 1, 2002, the cost report will be split into two different periods in which two different blended rates apply.

Effective for services furnished from April 1, 2002, to December 31, 2002, the blended amount for provider claims is equal to the sum of 80 percent of the current ambulance payment system amount (reasonable cost) and 20 percent of the ambulance fee schedule amount. The provider payment amount before consideration of deductible or coinsurance is the lower of (the blended amount) or (the interim rate times the billed charges).

During Year 2, the fee schedule amount is 40 percent of the blended amount and the provider's reasonable cost, or the supplier's reasonable charge will comprise the remaining 60 percent. During Year 3, the fee schedule amount is 60 percent of the blended amount and the provider's reasonable cost, or the supplier's reasonable charge will comprise the remaining 40 percent. During Year 4, the fee schedule amount is 80 percent of the blended amount and the provider's reasonable cost, or the supplier's reasonable charge will comprise the remaining 20 percent. Beginning with Year 5, e.g., for services and supplies furnished and mileage incurred, beginning January 1, 2006, and each year thereafter, the full fee schedule is entirely the Medicare allowed amount, and no portion of the provider's reasonable cost or the supplier's reasonable cost is included.

A. Payment Calculation During Transition

For claims with dates of service on or after April 1, 2002, and continuing through the transition, intermediaries 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.

For claims with dates of service from April 1, 2002, through December 31, 2002, intermediaries must determine a cost per ambulance trip based on the provider's ambulance costs and number of ambulance trips. A blended amount is determined, calculated based on the sum of the following:

- The provider's calculated cost per trip multiplied by 80 percent (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 percent of the providers cost per ambulance trip limit applicable to a particular service; and
- Twenty percent of the fee schedule amount that is a combination of the base rate and mileage payment. (Refer to subsection C below).

For calendar years after 2002, use the percentages described above (e.g., 40, 60, 80, and 100 where applicable for the year). However, cost-based amounts will be based on the initial cost established and updated using the inflation factor provided in the law. (CMS will provide the update factor as needed.)

NOTE: Rural mileage requires additional calculations, which are described in §20.1.6.B.

Deduct any applicable Medicare Part B deductible and coinsurance.

B. 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. The reasonable cost portion of this payment is based on the provider's reasonable cost per the program's usual rules.

C. Calculation of Fee Schedule Payment During Transition

Intermediaries pay providers based on the geographic location where the beneficiary is placed into the ambulance (point of pickup). Use the 5-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 5-digit ZIP Code on Form CMS-1450.

Intermediaries electronically crosswalk the ZIP Code to the appropriate carrier locality using the ZIP Code mapping file designating rural areas, which CMS supplies. Intermediaries consider all ZIP Codes on the list urban unless identified as rural (indicated with the letter “R” after the locality.) For correct reimbursement, the intermediaries crosswalk the carrier locality to the corresponding carrier locality code on the fee schedule.

For claims with dates of service on or after April 1, 2002, intermediaries pay the transitional blended rate. For the fee schedule portion of the blended rate the base rate and mileage rate amounts are as follows:

- If an urban ZIP Code is reported in conjunction with a ground or air HCPCS code, the FS portion is based on the urban adjusted base rate specific to the HCPCS code reported for that location. In addition, for mileage multiply the number of miles reported by the urban mileage amount specific to the HCPCS code reported.
- If a rural ZIP Code is reported for a ground HCPCS code, the FS portion is based on the urban adjusted base rate for that location, the rural mileage amount (1.5 times the urban mileage rate) for each of the first 17 loaded miles, and, for services furnished before January 1, 2004, the rural mileage rate for miles 18 through 50 (1.25 times the urban mileage rate) and, before January 1, 2004 the urban mileage payment rate for every mile over 50 miles, and on or after January 1, 2004, the urban rate for every mile over 17 miles.
- If a rural ZIP Code is reported in conjunction with an air HCPCS code, the FS portion is based on the rural base rate and rural mileage multiplied by the number of miles reported.

For each year of the transition period, intermediaries 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 percent 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% 2002 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% 2002 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% 2002 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% 2002 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

30.2.3 - SNF Billing

(Rev. 459, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

The following ambulance transportation and related ambulance services for residents in Part A stays are not included in the PPS rate. They may be billed as Part B services by the supplier only in the following situations:

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS code modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.)
- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS code ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date, and the SNF patient status (FL 22) is other than 30.)
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Nonhospital based dialysis facility).
- The ambulance trip is from the SNF to another SNF (the first and second character (origin and destination) of any ambulance HCPCS code modifier is "N" (SNF)) and the beneficiary is not in a Part A stay.

Ambulance payment associated with the following outpatient hospital service exclusions is paid under the ambulance fee schedule:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRIs);
- Ambulatory surgery involving the use of an operating room;
- Emergency services;
- Angiography;
- Lymphatic and Venous Procedures; and
- Radiology therapy.

Finally, ambulance transportation for removal, replacement, and insertion of PEG tubes is an excluded service under consolidated billing for Part A and is not considered an SNF service. Therefore, that ambulance is also excluded from SNF consolidated billing (CB), and the service would be billed to the carrier under Part B.

When not subject to SNF CB, claims for drugs and EKG testing administered during a transport to or from a SNF are separately payable during the AFS transition period only in those carrier jurisdictions that allowed separate payment for J-codes and EKG testing prior to the implementation of the AFS. (Only Method 3 and Method 4 suppliers in carrier jurisdictions that allowed separate payment for these services prior to April 1, 2002 may bill separately for J-codes and EKG testing during the transition period.)

Carriers in those jurisdictions that allow separate billing for J-codes and EKG testing apply the appropriate reasonable charge percentage for the AFS transition year (40% in 2004) to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the fee schedule, there is no FS portion for these codes.) In jurisdictions where separate payment for J-codes and EKG testing was not permitted prior to April 1, 2002, carriers shall deny supplier claims for such services.

The following ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and may not be billed as Part B services by the supplier. In these scenarios, the services provided are subject to SNF CB and the first SNF is responsible for billing the services to the intermediary:

- A beneficiary's transfer from one SNF to another before midnight of the same day. The first and second characters (origin and destination) of any HCPCS code ambulance modifier are "N" (SNF).

- A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport. When billing for ambulance transports, suppliers should indicate whether the transport was part of a SNF Part A covered stay, using the appropriate origin/destination modifier (e.g., “NH” for a transport from a SNF to a hospital).
- Suppliers should bill with an “NN” origin/destination modifier when a SNF to SNF transport occurs. A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport.
- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.). The first or second character (origin or destination) of any HCPCS code ambulance modifier is “D” (Diagnostic or therapeutic site other than P or H), and the other modifier (origin or destination) is “N” (SNF).

30.2.4 – Indian Health Service (IHS)/Tribal Billing

(Rev. 425, Issued: 01-10-05, Effective: 01-01-05, Implementation: 04-03-05)

Ambulance services originating out of IHS/ Tribal hospitals including Critical Access Hospitals (CAHs) that are hospital based ambulance services will be paid according to the appropriate payment methodology.

For IHS/Tribal CAH based ambulance services the appropriate payment methodology is cost based. 100 percent of the reasonable cost is paid for ambulance services to CAH based ambulance services which meet the 35 mile rule.

For IHS/Tribal hospital based ambulance services the appropriate payment methodology is 100 percent of the Federal rate of the ambulance fee schedule

30.3 – Ambulance Fee Schedule – Medical Conditions List and Instructions (Rev. 1185, Issued: 02-23-07, Effective: 04-01-07, Implementation: 04-02-07)

The Medical Conditions List is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patient’s condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient’s condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical conditions list information by themselves are not sufficient to justify coverage. All current Medicare ambulance policies remain in place.

The CMS issued the Medical Conditions List as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act (HIPAA)) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some carriers and fiscal intermediaries have Local Coverage Determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the Medical Conditions List is available for those who do find it helpful in justifying that services are reasonable and necessary.

The Medical Conditions List is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and can be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word “PLUS.” In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word “PLUS”) and at least one other ICD-9-CM code from the second part of the alternative listing (after the word “PLUS”). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes. Please see the example below:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the “PLUS any other code” requirement when using the alternative list for this condition (abnormal vital signs))). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not

on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an Advanced Life Support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a Basic Life Support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Information on appropriate use of transportation indicators:

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

- **Air and Ground**

- **Transportation Indicator “C1”:** Transportation indicator “C1” indicates an inter-facility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA regulations and guidelines. The patient’s condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.
- **Transportation Indicator “C2”:** Transportation indicator “C2” indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient’s condition is not available at the originating facility. The patient’s condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
- **Transportation Indicator “C3”:** Transportation indicator “C3” may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately Advanced Level Service responses. A code that describes the patient’s condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.
- **Transportation Indicator “C4”:** Transportation indicator “C4” indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appear to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.
- **Ground Only**
- **Transportation Indicator “C5”:** Transportation indicator “C5” has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.
- For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year-old beneficiary who has undergone cataract surgery at the Eye Surgery Center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction,

and insulin-dependent diabetes melitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

- **Transportation Indicator “C6”:** Transportation indicator “C6” has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation’s dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient’s condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.
- **Transportation Indicator C7-** Transportation indicator “C7” is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient’s condition should also be reported on the claim with a code selected from the list.
- **Air Only**
- All “transportation indicators” imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.
- D1 Long Distance - patient's condition requires rapid transportation over a long distance.
- D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
- D3 Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits to the patient.
- D4 Pick up point not accessible by ground transportation.

Ambulance Fee Schedule - Medical Conditions List
(Rev. 1185, Issued: 02-23-07, Effective: 04-01-07, Implementation: 04-02-07)

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
Emergency Conditions - Non-Traumatic						
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06,	Abdominal pain	Without other signs or symptoms	BLS		A0429

	789.07, or 789.09.					
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrhythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks, non- sinus tachycardias, PVC's >6, bi and trigeminy, ventricular tachycardia , ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED Fired	A0427/A0433
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799.	Abnormal vital signs (includes abnormal pulse oximetry).	With or without symptoms.	ALS		A0427/A0433

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69 or 995.7.	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior hx. Of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429

790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest— Resuscitation in progress		ALS		A0427/A0433
ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all- inclusive)	HCPCS Crosswalk

786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.99	933.0 or 933.1.	Choking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frost bite, other emergency conditions.	A0427/A0433
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions.	A0429
780.97	780.02, 780.03, or 780.09.	Altered level of consciousness (nontraumatic)		ALS	Acute condition with Glasgow Coma Scale<15.	A0427/A0433

780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, Seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
379.90	368.11, 368.12, or 379.91.	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429
ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all- inclusive)	HCPCS Crosswalk
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8.	Non traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac Symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0427/A0433

536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5.	Heat Exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429

459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11.	Hemorrhage	Severe (quantity) and potentially life-threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post-surgical bleeding.	A0427/A0433
ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429

987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7, 989.9, or 990.	Hazmat Exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical Device Failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.	A0427/A0433
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical Device Failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen System supply malfunction, orthopedic device failure.	A0429

436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic Distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433
ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
780.96		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7–10 for severe pain) or patient receiving pharmacologic intervention	A0427/A0433
724.5	724.2 or 785.9.	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433

724.9	724.2, 724.5, 847.1, or 847.2.	Back pain—non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
650	Any code from 660 through 669 or from 630 through 767.	Pregnancy complication/ Childbirth/Labor		ALS		A0427/A0433

292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433
ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick Person - Fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433

Emergency Conditions—Trauma

959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glasgow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20", 20" deformity in vehicle or 12" deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition Specific" Column	A0427/A0433
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433

	904.9.					
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429
ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPSC Crosswalk
880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433

869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0427/A0433

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429

994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near Drowning	Airway compromised during near drowning event.	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference Codes 959.8, 958.2, 869.0/869.1	A0427/A0433
ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk

995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429
Non-Emergency						
428.9		Cardiac/hemodynamic monitoring required en route.		ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.		ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.		BLS	Per transfer instructions.	A0428

786.09		Airway control/positioning required en route.		BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428
ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - in restraints.		BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428
293.1		Patient Safety: Danger to self or others - monitoring.		BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428

298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - seclusion (flight risk).		BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428
ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all- inclusive)	HCPCS Crosswalk

041.9		Special handling en route - isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain - orthopedic device.		BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428

719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route - positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures — post-op hip as an example	A0428
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Transportation Indicators

Transportation Indicators Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C1	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434

C2	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW		A0428, A0429, A0426, A0427, A0433, A0434
C3	Emergency Trauma Dispatch Condition Code	Major Incident or Mechanism of Injury	Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS Response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS Transport of ALS-level Patient	ALS-Level Condition treated and transport by a BLS-level ambulance	This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.	BLS		A0429

Transport Description Modifiers Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C6	ALS-level Response to BLS-level Patient	ALS Response Required based upon appropriate Dispatch Protocols - BLS-level patient transport	Indicates to Carrier/Intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare Ambulance Fee Schedule.	ALS		A0427
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.	ALS	Does not apply to self-administered IV medications.	A0426
Air Ambulance Transportation Indicators						

Air Ambulance Transportation Indicators		Transportation Indicator Description	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
D1		Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2		Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3		Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.	FW, RW		A0430, A0431
D4		Pick-up point not accessible by ground ambulance	FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be crosswalked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.

40 - Provider Ambulance Services Under Arrangements (Provider Billing)

(Rev. 1, 10-01-03)

B3-5117

Where payment is based on cost, Provider Reimbursement Manual §2104.1 provides that when provider ambulance services are furnished under arrangements, the charge to the provider by the ambulance company becomes the provider's cost. This charge must be reasonable, and the cost to the provider should not in any way, because of the arrangement, exceed what would have been the charge if the ambulance company had been permitted to bill the program directly, e.g., exceed the amount established as reasonable for such services by the carrier serving the same locality.

Close coordination between the intermediary and the carrier will be required to insure that the intermediary does not find costs to be reasonable which exceed the amounts which would be payable for the same services by the carrier. Carriers are required to make available the appropriate information on ambulance charges to the intermediary serving the same area.

In addition, the carrier should keep the intermediary informed of future revisions of reasonable charge data for ambulance services.

These rules apply through the transition period.

Where payment is made entirely under the fee schedule related costs should not be included in Medicare costs for the cost report.

50 - Carrier Disclosure to Suppliers

(Rev. 1, 10-01-03)

B-02-048

Beginning February 28, 2003, and continuing through 2005 (the transition period) carriers must disclose to each ambulance supplier the supplier's reasonable charge allowance for the forthcoming year (e.g., the full amount that would have been payable under reasonable charge for all ambulance services). Carriers must:

- For each supplier, prepare a reasonable charge disclosure package that includes, at a minimum, the reasonable charge amounts for each procedure code that the supplier is eligible to bill. Carriers do not need to disclose the reasonable charge amount for procedure codes that the supplier does not routinely bill. The disclosure package may include other reasonable charge amounts (e.g., prevailing rate, prevailing IIC, customary charge, customary IIC). However, carriers must indicate the reasonable charge allowed amount, e.g., the principle payment amount of the prevailing, prevailing IIC, customary, or customary IIC, and the corresponding HCPCS code.

- Provide the data for only those procedure codes that apply to each supplier's particular billing method. For Method 2 and Method 3 ambulance suppliers, carriers provide the reasonable charge amounts for codes A0425 through A0436. If providing the reasonable charge amounts for the old HCPCS codes, carriers use A0300 - A0370 and provide a crosswalk to the new codes. For Method 3 and 4 suppliers, carriers also include the applicable item/supply codes (e.g., the reasonable charge amounts for A0384, A0392, A0394, A0396, and A0398).
- Wherever possible, use the new HCPCS codes. They must clearly indicate that the corresponding amounts are the full reasonable charge amounts, e.g., the 100 percent reasonable charge amounts, and specify what portion of the charge is reimbursable within the current transition year. (For 2002, 80 percent of the total reasonable charge amount is reimbursable.) If old or deleted HCPCS codes are used, carriers must include a crosswalk in the disclosure package that maps each HCPCS code to the new replacement procedure code. The crosswalk may be provided as part of the disclosure statement or as a separate insert included as an enclosure with the disclosure.
- Send each supplier its disclosure package in accordance with the timetable specified below. Publication of the reasonable charge disclosure is contingent upon the release of the ambulance inflation factor (AIF). If multiple AIFs are issued in the same calendar year, carriers must prepare a separate disclosure package to notify suppliers of the appropriate amounts and dates of service for each AIF.
- Assure that ambulance suppliers are aware of the ambulance fee schedule yearly payment blend percentages and the location of the ambulance fee schedule on the CMS Web site <http://www.cms.hhs.gov/medlearn/refamb.asp>.

Carriers must adhere to the following schedule of disclosure activities:

- **For CY 2003, on or before February 28, 2003** - Mail to each ambulance supplier, the supplier's 2002 reasonable charge allowance, updated by the 2003 AIF. If applicable, include a crosswalk that maps each HCPCS code to the new replacement procedure code.
- **(NOTE:** Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)
- **For CY 2004, on or before December 31, 2003** - Mail to each ambulance supplier, the supplier's reasonable charge allowance for 2003, updated by the 2004 AIF. If applicable, include a crosswalk that maps each HCPCS code to the new replacement procedure code.
- **(NOTE:** Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)
- **For CY 2005, on or before December 31, 2004** - Mail to each ambulance supplier, the supplier's reasonable charge allowance for 2004, updated by the 2005 AIF. If

applicable, include a crosswalk that maps each HCPCS code to the new replacement procedure code.

- **(NOTE:** Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)

30.3. Attachment 1 (Rev. 395, 12-15-04)

Ambulance Fee Schedule - Medical Conditions List

The following list is intended as primarily an educational guideline. It will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the codes does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the HCPCS code or the condition code by themselves. All current Medicare ambulance policies remain in place.

IMPORTANT NOTE: DO NOT use the Condition Code # on the Ambulance Claim Form, use the ICD-9-CM Code.

#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
Emergency Conditions (non-traumatic)							

1	789.00	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433	
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk	
2	789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09.	Abdominal pain	Without other signs or symptoms	BLS		A0429	
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk	

3	427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrhythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6, bi and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED Fired	A0427/A0433
4	780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
5	796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799.	Abnormal vital signs (includes abnormal pulse oximetry).	With or without symptoms.	ALS		A0427/A0433
6	995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69 or 995.7.	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior hx. Of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433

#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
7	692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
8	790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
9	799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
10	786.05		Difficulty breathing		ALS		A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
11	427.5		Cardiac arrest—Resuscitation in progress		ALS		A0427/A0433

12	786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
13	784.9	933.0 or 933.1.	Choking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
14	991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frost bite, other emergency conditions.	A0427/A0433
15	991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions.	A0429
16	780.01	780.02, 780.03, or 780.09.	Altered level of consciousness (nontraumatic)		ALS	Acute condition with Glasgow Coma Scale<15.	A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
17	780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions/Seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
18	379.90	368.11, 368.12, or 379.91.	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429
19	437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8.	Non traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk

20	785.1		Cardiac Symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0427/A0433
21	536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
22	992.5	992.0, 992.1, 992.3, 992.4, or 992.5.	Heat Exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
23	992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
24	459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11.	Hemorrhage	Severe (quantity) and potentially life-threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post-surgical bleeding.	A0427/A0433

25	038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
26	987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7, 989.9, or 990.	Hazmat Exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
27	996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical Device Failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.	A0427/A0433
28	996.30	996.31, 996.4, or 996.59.	Medical Device Failure	Health maintenance device failures that cannot be resolved on location.	BLS	OS supply malfunction, orthopedic device failure.	A0429

29	436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic Distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
30	780.99		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7–10 for severe pain) or patient receiving pre-hospital pharmacologic intervention.	A0427/A0433
31	724.5	724.2 or 785.9.	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
32	724.9	724.2, 724.5, 847.1, or 847.2.	Back pain—non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms	ALS	Neurologic distress list.	A0427/A0433
33	977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
34	305.00	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
35	977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or	ALS		A0427/A0433

				potentially resulting in airway compromise.			
36	998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
37	650	Any code from 660 through 669 or from 630 through 767.	Pregnancy complication/ Childbirth/Labor		ALS		A0427/A0433
38	292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433
39	298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
40	036.9	780.6 PLUS either 784.0 or 723.5.	Sick Person - Fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
41	787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects	ALS		A0429

				of dehydration.			
42	780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
				Emergency Conditions—Trauma			
43	959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme.	ALS	Trauma with one of the following: Glasgow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
44	518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433

45	958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9.	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
46	829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429
47	880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
48	886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
49	887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433
50	869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk

51	949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma;	A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
52	949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429
53	989.5		Animal bites/sting/envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
54	879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
55	994.0		Lightning		ALS		A0427/A0433
56	994.8		Electrocution		ALS		A0427/A0433
#	ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPC Crosswalk
57	994.1		Near Drowning	Airway compromised during near drowning event.	ALS		A0427/A0433

58	921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
59	995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference Codes 959.8, 958.2, 869.0/869.1	A0427/A0433
60	995.8	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429
#	ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples	HCPC Crosswalk
				Non-Emergency			
61	428.9		Cardiac/hemodynamic monitoring required en route.	ALS	Expectation monitoring is needed before and after transport.	A0426	
62	518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.	ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434	

63	Need Code		IV meds required en route.	ALS	Does not apply to self-administered IV medications.	A0426	
64	293.0		Chemical restraint.	ALS		A0426	
65	496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.	BLS	Per transfer instructions.	A0428	
#	ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples	HCPC Crosswalk
66	786.09		Airway control/positioning required en route.	BLS	Per transfer instructions.	A0428	
67	496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.	BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428	
68	298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - in restraints.	BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428	
69	293.1		Patient Safety: Danger to self or others - monitoring.	BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428	
#	ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples	HCPC Crosswalk
70	298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - seclusion (flight risk).	BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428	

71	781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428
72	041.9		Special handling en route - isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
#	ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples	HCPC Crosswalk
73	907.2		Special handling en route to reduce pain - orthopedic device.		BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428
74	719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route - positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures —post-op hip as an example. #	A0428
Modifiers							
Transport Description Modifiers Air and Ground*		Transport Category	Modifier Description		Service Level	Comments and Examples	HCPC Crosswalk
A	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.		BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434
B	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW	MUST specify what service is not available on the submitted claim in the narrative/comment field.		A0428, A0429, A0426, A0427, A0433, A0434

C	ALS level Response to BLS level Patient	ALS Response Required based upon appropriate Dispatch Protocols - BLS level patient transport	Indicates to Carrier/Intermediary that an ALS level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Ambulance Medicare Fee Schedule.	ALS	Must specify BOTH conditions on the claim - initial condition would indicate the BLS level condition of the patient during transport and the second would indicate the ALS level condition that describes the information received at the time of dispatch	A0427	
Transport Description Modifiers Air and Ground*	Transport Category	Modifier Description		Service Level	Service Level	Comments and Examples	HCPC Crosswalk
D	Medically necessary transport but not to the nearest facility.	BLS or ALS Response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.	
E	BLS Transport of ALS-level Patient	ALS-Level Condition treated and transport by a BLS-level ambulance	This modifier is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.	BLS	This code MUST be submitted on the claim in addition to the code whenever a BLS-level ambulance transports a patient presenting an ALS-level condition.	A0429	

F	Emergency Trauma Dispatch Condition Code	Major Incident or Mechanism of Injury	Major Incident-This modifier is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
		Air Ambulance Transport Modifiers				
Air Ambulance Transport Modifiers		Modifier Description		Service Level	Comments and Examples	HCPC Crosswalk
Air-A		Long Distance-patient's condition requires rapid transportation over a long distance		FW, RW	If the patient's condition warrants only.	A0430, A0431
Air-B		Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.		FW, RW		A0430, A0431
Air-C		Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.		FW, RW		A0430, A0431
Air-D		Pick-up point not accessible by ground ambulance		FW, RW		A0430, A0431

Note: HCPC Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be crosswalked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1463CP	02/22/2008	ZIP Code Files by Date of Service	07/07/2008	5881
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1375CP	11/09/2007	Ambulance Inflation Factor for CY 2008	01/07/2008	5801
R1333CP	08/17/2007	Ambulance: New Remark Code for Denying Separately Billed Services	10/01/2007	5659
R1318CP	08/17/2007	Ambulance: New Remark Code for Denying Separately Billed Services - Replaced by Transmittal 1333	10/01/2007	5659
R1249CP	05/25/2007	Update to Publication 100-04, Chapters 1 and 15 for ZIP5 and ZIP9 Medicare Zip Code Files.	10/01/2007	5578
R1185CP	02/23/2007	Ambulance Fee Schedule-Medical Conditions List	04/02/2007	5442
R1144CP	12/29/2006	Elimination of CMS-1491 and CMS-1490U Forms	04/02/2007	5390
R1102CP	11/03/2006	Ambulance Inflation Factor (AIF) for CY 2007	01/02/2007	5358
R1100CP	11/03/2006	Jurisdiction for Ambulance Supplier Claims	01/01/2008	5203
R852CP	02/10/2006	Corrected Ambulance Fee Schedule file for CY 2006	02/24/2006	4362
R789CP	12/23/2005	Ambulance Medical Conditions List	03/27/2006	4221
R762CP	11/25/2005	Ambulance Inflation Factor (AIF) for CY 2006	01/03/2006	4061
R668CP	09/02/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
R622CP	07/29/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933

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<u>R459CP</u>	02/04/2005	Change To CWF SNF Edits For Consolidated Billing for Ambulance Transport to or From Therapeutic Sites -- replaces R342CP	04/04/2005	3676
<u>R437CP</u>	01/21/2005	This instruction revises Section 30, Chapter 6 to include ICD-9-CM coding guidance for Skilled Nursing Facilities (SNFs) and removes Home Health Agency (HHA) Types of Bill from various sections of Chapter 15 to conform with existing policy.	02/22/2005	3664
<u>R425CP</u>	01/10/2005	Payment of Ambulance Services to Indian Health Service (IHS) or Tribal Hospitals Including (CAHs)	04/03/2005	3521
<u>R411CP</u>	12/23/2004	Ambulance Inflation Factor (AIF) for CY 2005	01/03/2005	3599
<u>R395CP</u>	12/15/2004	Ambulance Fee Schedule - Medical Conditions List	01/03/2005	3619
<u>R367CP</u>	11/12/2004	Replaced by <u>Revision 425CP</u>	04/04/2005	3521
<u>R342CP</u>	10/29/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site	04/04/2005	3427
<u>R220CP</u>	06/25/2004	Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003	07/06/2004	3099
<u>R212CP</u>	06/18/2004	Replaced by <u>Revision 220CP</u>	07/06/2004	3099
<u>R185CP</u>	05/28/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Drugs and Electrocardiogram (EKG) Testing Provided During an Ambulance Transport	10/04/2004	3212
<u>R163CP</u>	04/30/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site Other than a Physician's Office or Hospital	10/04/2004	3196

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<u>R088CP</u>	02/06/2004	Implementation of Changes to Payment for Ambulance Services Required by Section 414 of MMA	07/05/2004	3099
<u>R059CP</u>	01/02/2004	Corrects the "Ambulance HCPCS Codes Crosswalk and Definitions," makes technical corrections to the manual, and adds a new carrier requirement for HCPCS code A0800	01/05/2004	3035
<u>R056CP</u>	12/24/2003	Ambulance Inflation Factor (AIF) for CY 2004 including the 2004 AIF for determining the payment limit for ambulance services required by §1834(1) of the Social Security Act (the Act), the blending percentages applicable to CY 2004, and the address of the ambulance fee schedule file for CY 2004	01/05/2004	3000
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA