CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 668

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: SEPTEMBER 2, 2005

Change Request 3933

Transmittal 622, dated July 29, 2005 is rescinded and replaced with Transmittal 668, dated September 2, 2005. The only changes are in the last sentence of the SUMMARY OF CHANGES paragraph on this transmittal and the Background paragraph in the Business Requirements attachment to show "payment by carriers" instead of "payment to carriers." All other information remains the same.

SUBJECT: Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay

I. SUMMARY OF CHANGES: As a result of reports from the Boston Regional Office of the Inspector General (OIG), CMS has been made aware of improper payments for ambulance services provided to hospital inpatients by independent suppliers of ambulance services. Sections 1882(a)(14), 1886(d) and (g) of the Social Security Act as well as CFR 411.15(m) exclude payment for ambulance services furnished to hospital inpatients within the admission and discharge dates unless billed directly by the hospital or furnished under arrangements. With the exception of the admission and discharge dates, all transportation provided to hospital inpatients must be bundled to the hospital. Ambulance services that are billed to the carrier with a date of service that falls within the admission or discharge date on a hospital inpatient bill shall be rejected. There are currently no edits in the Common Working File (CWF) to prevent payment by carriers for services that are bundled in the hospital's payment.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : Ambulance claims received on or after January 3, 2006, and 4 years after initial determination for adjustments

IMPLEMENTATION DATE : January 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/Table of Contents
N	3/10.5/Hospital Inpatient Bundling
R	15/Table of Contents
R	15/10/General Coverage and Payment Policies
N	15/30.1.4/CWF Editing of Ambulance Claims for Inpatients
R	15/30.2/Intermediary Guidelines
R	15/30.2.1/Provider/Intermediary Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instructions

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal 668	Date: September 2, 2005	Change Request 3933

Transmittal 622, dated July 29, 2005 is rescinded and replaced with Transmittal 668, dated September 2, 2005. The only changes are in the last sentence of the SUMMARY OF CHANGES paragraph on the transmittal and the Background paragraph in the Business Requirements attachment to show "payment by carriers" instead of "payment to carriers." All other information remains the same.

SUBJECT: Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay

I. GENERAL INFORMATION

A. Background: As a result of reports from the Boston Regional Office of the Inspector General (OIG), CMS has been made aware of improper payments for ambulance services provided to hospital inpatients by independent suppliers of ambulance services. §1882(a)(14), 1886(d) and (g) of the Social Security Act as well as CFR 411.15(m) exclude payment for ambulance services furnished to hospital inpatients within the admission and discharge dates unless billed directly by the hospital or furnished under arrangements. As a result, the independent supplier of ambulance services must look to the hospital, rather than to the beneficiary or carrier, for payment. With the exception of the admission and discharge dates, all transportation provided to hospital inpatients must be bundled to the hospital. Ambulance services that are billed to the carrier with a date of service that falls within the admission or discharge date on a hospital inpatient bill shall be rejected. There are currently no edits in the Common Working File (CWF) to prevent payment by carriers for services that should be bundled in the hospital's payment.

B. Policy: Ambulance transportation that is provided within the admission and discharge dates for hospital inpatients by an independent supplier of ambulance services shall not be paid separately as a Part B service.

The CWF shall reject an ambulance line item received by the carrier from an independent supplier of ambulance services when the ambulance line item service date falls within the admission and discharge dates on a hospital inpatient bill that is posted to the CWF. The CWF reject shall indicate that the ambulance transportation occurred during a hospital inpatient stay, and is not separately payable. The CWF will bypass the reject edit when the ambulance line item service date is the same as the admission or discharge date on a hospital inpatient bill. If the ambulance claim is received prior to the hospital inpatient bill, upon receipt of the hospital inpatient bill CWF shall generate an unsolicited response to the carrier that processed the claim indicating the ambulance line item should be adjusted and payment recouped.

The CWF shall perform an additional edit before determining if the ambulance line item should be rejected when the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF) or inpatient rehabilitation facility (IRF) and is transported via ambulance to an acute care hospital to receive specialized services. The CWF shall edit the claim for the presence of occurrence span code 74 (non-covered level of care) and the associated occurrence span code from and through dates. The CWF shall bypass the reject edit when the ambulance line item service date falls within the occurrence span code 74 from and through dates plus one day. In this case, the ambulance line item is separately

payable. The CWF shall reject the ambulance line item when the service date falls outside of the occurrence span code 74 from and through dates plus one day. If the ambulance claim is received prior to the LTCH, IPF or IRF bill, upon receipt of the hospital inpatient bill CWF shall generate an unsolicited response to the carrier that processed the claim indicating the ambulance line item should be adjusted and payment recouped.

Based on the CWF line item rejects, carriers shall deny ambulance line items that should be bundled to the hospital. Appeals rights shall be offered on all denials. Standard systems shall develop, and along with carriers shall implement, an automated resolution process whereby when they receive a reject from CWF, they shall pay those services correctly billed and deny only those services on the claim incorrectly billed to them.

CWF shall allow an override of the reject for carrier use, where in the course of pursuing a reconsideration, a provider or supplier may bring to the attention of the carrier a situation where services on a claim have been denied, but should actually be allowed to be paid through the carrier. At the carrier's discretion, the carrier may use the override code to allow that claim to process through CWF to payment. The override code will be specified in the CWF documentation.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3933.1	The CWF System Maintainer shall create an edit to reject a Part B ambulance specialty "59" line item received on or after 01/3/2006 with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay posted to the CWF.								X	
3933.1.1	Effective for claims received on or after 01/3/2006, the carrier shall reject a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay posted to the CWF.			X			X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3933.1.2	The carrier shall use Remittance Advice Remark Code M2: "Not paid separately when the patient is an inpatient," when rejecting a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay posted to the CWF.			X			X			
3933.1.3	The carrier shall use MSN message 16.27: "This service is not covered since our records show you were in the hospital at this time," when rejecting a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay posted to the CWF.			X			X			
3933.1.4	The CWF System Maintainer shall bypass the edit on a Part B ambulance specialty "59" line item in the following situations: - the incoming Part B ambulance line item service date matches the admission or discharge date of a covered hospital inpatient stay posted to the CWF, - the Part B ambulance claim is a cancel only claim (Action Code 3), - the Part B ambulance claim is an accrete claim (Action Code 9), - the Part B ambulance service has a Payment Process Indicator other than A (allowed), or - the CWF override code used for bundling is present.								X	
3933.2	The CWF System Maintainer shall add to the unsolicited process the edit logic for rejecting a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates on an incoming hospital inpatient bill.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3933.2.1	The carrier shall adjust a Part B ambulance specialty "59" line item and recoup the payment when an unsolicited response is received for a line item with a service date that falls within the admission and discharge dates on an incoming hospital inpatient bill.			X			X			
3933.2.2	The carrier shall use Remittance Advice Remark Code M2: "Not paid separately when the patient is an inpatient," when adjusting a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates on an incoming hospital inpatient bill.			X			X			
3933.2.3	The carrier shall use Remittance Advice (RA) Adjustment Reason Code 97 "Payment is included in the allowance for another service/procedure", when adjusting a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates on an incoming hospital inpatient bill.			X			X			
3933.2.4	The carrier shall use MSN message 16.27: "This service is not covered since our records show you were in the hospital at this time," when adjusting a Part B ambulance specialty "59" line item with a service date that falls within the admission and discharge dates on an incoming hospital inpatient bill.			X			X			
3933.3	The CWF System Maintainer shall create an edit to reject a Part B ambulance specialty "59" line item received on or after 01/3/2006 with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF bill posted to the CWF.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3933.3.1	Effective for claims received on or after 01/3/2006, the carrier shall reject an incoming Part B ambulance specialty "59" line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF bill posted to the CWF.			X			X			
3933.3.2	The carrier shall use Remittance Advice Remark Code M2: "Not paid separately when the patient is an inpatient," when rejecting a Part B ambulance specialty "59" line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF bill posted to the CWF.			X			X			
3933.3.3	The carrier shall use MSN message 16.27: "This service is not covered since our records show you were in the hospital at this time," when rejecting a Part B ambulance specialty "59" line item with a date of service that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF bill posted to the CWF.			X			X			
3933.3.4	The CWF System Maintainer shall bypass the edit on a Part B ambulance specialty "59" line item in the following situations: - the service date on the incoming Part B ambulance service line item falls within the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF bill posted to the CWF. - the Part B ambulance claim is a cancel only claim (Action Code 3), - the Part B ambulance claim is an accrete claim (Action Code 9), - the Part B ambulance service has a Payment Process Indicator other than A (allowed), or								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	- the CWF override code used for bundling is present.									
3933.4	The CWF System Maintainer shall add to the unsolicited process the edit logic for adjusting a Part B ambulance specialty "59" line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming LTCH, IPF or IRF bill.								X	
3933.4.1	The carrier shall adjust the Part B ambulance specialty "59" line item and recoup the payment when an unsolicited response is received for a line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming LTCH, IPF or IRF bill.			X			X			
3933.4.2	The carrier shall use Remittance Advice Remark Code M2: "Not paid separately when the patient is an inpatient," when adjusting a Part B ambulance specialty "59" line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming LTCH, IPF or IRF bill.			X			X			
3933.4.3	The carrier shall use Remittance Advice (RA) Adjustment Reason Code 97 "Payment is included in the allowance for another service/procedure", when adjusting a Part B ambulance specialty "59" line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming LTCH, IPF or IRF bill.			X			X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3933.4.4	The carrier shall use MSN message 16.27: "This service is not covered since our records show you were in the hospital at this time," when adjusting a Part B ambulance specialty "59" line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming LTCH, IPF or IRF bill.			X			X			
3933.5	Carriers should not search their files to either retract payment or retroactively pay claims.			X						
3933.6	Carriers shall adjust claims if they are brought to their attention.			X						
3933.7	Carriers and standard systems shall implement an automated resolution process for CWF rejects, paying those services correctly billed and denying those services on the claim incorrectly billed.			X			X			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3933.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: CWF shall set up test Health Insurance Claim Numbers (HICNs) and unsolicited responses to be used by the carrier for testing.

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: Ambulance claims received on or after January 3, 2006, and 4 years after initial determination for adjustments **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Susan Guerin (410-786-6138) or susan.guerin@cms.hhs.gov (for FI related issues) or Joan Proctor Young (410-786-0949) or (joan.proctoryoung@cms.hhs.gov for carrier related issues) **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Unless otherwise specified, the effective date is the date of service.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev.668, 09-02-05)

10.5 – Hospital Inpatient Bundling

(Rev.668, Issued: 09-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay. The Common Working File (CWF) performs reject edits to incoming claims from independent suppliers of ambulance services. The CWF searches paid claim history and compares the line item service date on an ambulance claim to the admission and discharge dates on a hospital inpatient stay. The CWF rejects the line item when the ambulance line item service date falls within the admission and discharge dates on a hospital inpatient claim. Based on CWF rejects, the carrier must deny line items for ambulance services billed by independent suppliers that should be bundled to the hospital.

Upon receipt of a hospital inpatient claim, 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 an independent supplier. The CWF shall 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 the unsolicited response, the carrier shall 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.

The CWF performs an additional edit before determining if the ambulance line item should be rejected when the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF) or inpatient rehabilitation facility (IRF) and is transported via ambulance to an acute care hospital to receive specialized services. The CWF edits the claim for the presence of occurrence span code 74 (non-covered level of care) and the associated occurrence span code from and through dates. The CWF bypasses the reject edit when the ambulance line item service date falls within the occurrence span code 74 from and through dates plus one day. In this case, the ambulance line item is separately payable. The CWF rejects the ambulance line item when the service date falls outside the occurrence span code 74 from and through dates plus one day.

Medicare Claims Processing Manual
Chapter 15 - Ambulance

Table of Contents

(Rev.668, 09-02-05)

10 - General Coverage and Payment Policies

(Rev.668, Issued: 09-02-05, Effective: 01-03-06, Implementation: 01-03-06)

These instructions apply to processing claims to carriers and intermediaries 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 21, 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 must 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 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.*

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: 01-03-06, 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.668, Issued: 09-02-05, Effective: 01-03-06, Implementation: 01-03-06)

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 FLs 39-41 "Value Codes." The value code is defined as "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance." Providers report the number in dollar portion of the form location right justified to the left to the dollar/cents delimiter. Providers utilizing the UB-92 flat file use Record Type 41 fields 16-39. On the X-12 institutional claims transactions, providers show HI*BE:A0:::12345~, 2300 Loop, HI segment.

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

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 in FL 44 "HCPCS/Rates" 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 in FL 44 "HCPCS/Rates" 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.

E. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided in FL 44 "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 on the hard copy UB-92 in FL 45 "Service Date" (MMDDYY), and on RT 61, field 13, "Date of Service" (YYYYMMDD) on the UB-92 flat file.

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 FL 46 "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 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 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 FL 48 "Noncovered Charges" to avoid nonacceptance of the claim.

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 UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0428	RH	QN	082701	1 (trip)	100.00
61	0540	A0380	RH	QN	082701	4 (mileage)	8.00

For the hard copy UB-92 (Form CMS-1450), providers report as follows:

FL 42	FL 44	FL 45	FL 46	FL 47
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2 - Claim containing multiple ambulance trips:
For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0429	RH	QN	082801	1 (trip)	100.00
61	0540	A0380	RH	QN	082801	2 (mileage)	4.00
61	0540	A0330	RH	QN	082901	1 (trip)	400.00
61	0540	A0390	RH	QN	082901	3 (mileage)	6.00
61	0540	A0426	RH	QN	083001	1 (trip)	500.00
61	0540	A0390	RH	QN	083001	5 (mileage) 10.00	
61	0540	A0390	RH	QN	082901	3 (mileage)	6.00
61	0540	A0426	RH	QN	083001	1 (trip)	500.00

For the hard copy UB-92 (Form CMS-1450), providers report as follows:

FL 42	FL 44	Modifier		FL 45	FL 46	FL 47
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00

EXAMPLE 3 - Claim containing more than one ambulance trip provided on the same day:
For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0429	RH	QN	090201	1 (trip)	100.00
61	0540	A0380	RH	QN	090201	2 (mileage)	4.00
61	0540	A0429	HR	QN	090201	1 (trip)	100.00
61	0540	A0380	HR	QN	090201	2 (mileage)	4.00

For the hard copy UB-92 (CMS-1450), providers report as follows:

FL 42	FL 44	Modifier		FL 45	FL 46	FL 47
		#1	#2			
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: 01-03-06, 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 am 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.