CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2383	Date: January 12, 2012
	Change Request 7557

Transmittal 2336 dated October 28, 2011, is rescinded and replaced by Transmittal 2383, dated January 12, 2012, to modify business requirement 7557.6 to update the HCPCS range. The Effective and Implementation dates have not been changed. All other information remains the same.

SUBJECT: FISS Claims Processing Updates for Ambulance Services.

I. SUMMARY OF CHANGES: Pursuant to the CY 2011 MPFS final rule, this CR implements the requirement to report based on fractional mileage units for ambulance services. Providers who bill on the paper UB-04 are required to bill ambulance mileage that is rounded up to the nearest tenth of a mile. Additionally, system changes are needed in order to comply NPI requirements for Ambulance services.

EFFECTIVE DATE: For UB-04 Hardcopy Claims, August 1, 2011. For NPI requirement changes, April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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-

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/30.2.1/A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is

not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Pub.100-04	Transmittal: 2383	Date: January 12, 2012	Change Request: 7557

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SUBJECT: FISS Claims Processing Updates for Ambulance Services

Effective Date: For UB-04 Hardcopy Claims, August 1, 2011. For NPI requirement changes, April 1, 2012
Implementation Date: April 2, 2012

I.   GENERAL INFORMATION:

   A. Background: Pub.100-04, Medicare Claims Processing Manual, chapter 15, 30.2.1, requires that ambulance providers submitting claims to the FI/A/B/MACs, utilize the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. On January 1, 2011, fractional mileage billing was implemented for electronic claims. However, for FI/A/B MAC claims processing, the hardcopy UB-04 form could not accommodate fractional billing, therefore, hardcopy billers were instructed to continue to use previous ambulance billing instructions provided in §30.2.1. That is, providers that are permitted to file paper UB-04 claims would continue to round up to the nearest whole mile. Effective August 1, 2011, the NUBC has updated instructions for reporting units that now allows for fractional unit billing, therefore, CMS is now providing notice that the exception to bill whole units on paper ambulance claims is now rescinded.

   Additionally, when NPI regulations were implemented Pub.100-04, Medicare Claims Processing Manual, Chapter 25, 75.5, stated that the attending provider name and identifiers (including NPI) were required when claim/encounter contains any services other than nonscheduled transportation services. If the claim/encounter was for nonscheduled transportation services the attending provider name and identifiers (including NPI) were not required.

   B. Policy: Effective for paper claims with dates of service on and after January 1, 2011, received on or after August 1, 2011, ambulance providers must report mileage units rounded up to the nearest tenth of a mile for all claims for mileage totaling less than 100 covered miles. Providers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Contractors shall truncate mileage units with fractional amounts reported to greater than one decimal place; e.g., 99.99 will become 99.9 after truncating the hundredths place. For mileage totaling less than 1 mile, a "0" prior to the decimal point (e.g., 0.9) is used for claims processing. Contractors shall add a leading zero if the paper claim does not contain one.

II.   BUSINESS REQUIREMENTS TABLE

Use of "Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		M A C	M A C	R I E R	I	F I S S	M C S	V M S	C W F
7557.1	Contractors shall accept and process paper claims with ambulance services, identified by revenue code 0540, with fractional mileage units rounded reported in Form Locator (FL) 46.	X	X			X			
7557.1.1	Contractors shall accept and process claims with fractional mileage units up to one decimal place (i.e., the tenths place) on ambulance claims submitted on paper.	X	X			X			
7557.1.2	Contractors shall truncate fractional mileage units rounded to greater than one decimal place on ambulance revenue code 0540 lines on paper claims. For example, if 1.23 miles are submitted, contractors shall automatically convert the units to 1.2 and process the paper claim accordingly.	X	X			X			
7557.2	Contractors shall accept and process paper claims with ambulance services, identified by revenue code 0540, submitted with less than 1 whole mileage unit reported in FL 46.	X	X			X			
7557.3	On paper claims for ambulance mileages totaling less than 1 mile that are submitted without a leading "0", contractors shall infer the leading "0". For example, if the ambulance provider submits ".9" miles, contractors shall automatically convert the units to "0.9" and process the claim accordingly.	X	X			X			
7557.4	Contractors shall continue to accept and process paper claims with ambulance services, identified by revenue code 0540, submitted with whole number miles for trips totaling 100 covered miles and greater as reported in FL 46.	X	X			X			
7557.5	Contractors shall truncate fractional mileage totaling 100 miles or greater submitted on ambulance revenue code 0540 lines. For example, if 100.5 mileage units are submitted, contractors shall automatically convert the units to 100 and process the paper claim accordingly.	X	X			X			
7557.6	Contractors shall update system logic to not require an attending provider name and NPI identifier on emergency ambulance transport claims billed with HCPCS: A0427, A0429, A0430, A0431, A0432, A0433, A0434, or A0428 (when A0428 is billed with the modifier QL).	X	X			X			

III.   PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7557.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV.   SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use of "Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: CR 7065

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke at fred.rooke@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)***:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation
(Rev. 2383, Issued: 01-12-12, Effective: For UB-04 Hardcopy Claims, August 1, 2011. For NPI requirement changes, April 1, 2012, Implementation: 04-02-12)

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 6 – SNF Inpatient Part A Billing, Section 20.3.1 – Ambulance Services for additional information on SNF consolidated billing and ambulance transportation.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing, section 10.5 – Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

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

The provider must furnish the following data in accordance with A/MAC instructions. The A/MAC 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 HCPCS codes established for the ambulance fee schedule. No other HCPCS codes are acceptable for the reporting of ambulance services and mileage. The HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used.

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.

For UB-04 hard copy claims submission prior to August 1, 2011, 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.

Beginning with dates of service on or after January 1, 2011, for UB-04 hard copy claims submissions August 1, 2011 and after, mileage must be reported as fractional units. When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

For electronic claims submissions prior to January 1, 2011, 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.

Beginning with dates of service on or after January 1, 2011, for electronic claim submissions only, mileage must be reported as fractional units in the ANSI X12N 837I element SV205 for trips totaling up to 100 covered miles. When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, providers must report mileage rounded up to the nearest whole number mile (e.g., 999) and not use a decimal when reporting whole number miles over 100 miles.

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

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 non-covered charges. A/MACs should assign ANSI Group Code OA to the $1.00 non-covered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

F. Edits (A/MAC Claims with Dates of Service On or After 4/1/02)

For claims with dates of service on or after April 1, 2002, A/MACs 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.

- Beginning with dates of service on or after April 1, 2012, edit to assure that only non-emergency trips (i.e., HCPCS A0426, A0428 [when A0428 is billed without modifier QL]) require an NPI in the Attending Physician field. Emergency trips do not require an NPI in the Attending Physician field (i.e., A0427, A0429, A0430, A0431, A0432, A0433, A0434 and A0428 [when A0428 is billed with modifier QL])

G. CWF (A/MACs)

A/MACs 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 A/MAC 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."